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Fetal Protection Laws: Moral Panic and the New Constitutional Battlefield

Michele Goodwin

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Fetal Protection Laws: Moral Panic and the New Constitutional Battlefield

Michele Goodwin*

Increasingly, state statutes are the primary means through which legal norms affecting low-income pregnant women's autonomy, privacy, and liberty are introduced and shaped. Arrests, forced bed rests, compelled cesarean sections, and civil incarcerations of pregnant women in Alabama, Florida, Indiana, Iowa, Mississippi, New Mexico, South Carolina, Texas, Utah, and Wisconsin merely scratch the surface of a broad attack on pregnant women. This recent era of maternal policing reshapes physician and police interactions with pregnant women accused of violating fetal protection laws (FPLs); inspires (and sometimes requires) medical officials to breach confidentiality when treating pregnant women; motivates selective prosecution against poor women, particularly

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those of color; and evinces improper judicial deference to medical authority rather than law.

This Article makes three claims. First, it argues that doctors breach what should be an unwavering duty of confidentiality to pregnant patients by trampling the well-established expectations of the patient-physician relationship. Second, it argues that even if states' chief goal is to promote fetal health by enacting protectionist laws, punitive state interventions contravene that objective and indirectly undermine fetal health. Finally, the Article argues that FPLs unconstitutionally situate pregnant women as unequal citizens by unjustly denying them basic human and legal rights afforded other citizens.

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INTRODUCTION

Imagine a time when fetal protection legislation emboldens a state’s attorney to prosecute a pregnant woman for smoking a cigarette.¹ On the one hand, inhaling nicotine and carcinogens undoubtedly risks both pregnant women’s health and that of their fetuses.² On the other hand, cigarette smoking is otherwise a rigorously defended legal activity. State governments persistently choose not to ban cigarette smoking, despite concerns for public health and safety and ongoing civil litigation against tobacco companies. But does the state’s asserted special solicitude for fetal health justify prosecuting pregnant women for smoking, and would such prosecution pass constitutional muster?

When the state chooses to prosecute a pregnant woman for threatening fetal health, it raises a host of questions. Under what circumstances and justifications does it do so? Why does some conduct during pregnancy and not others raise red flags and lead to punitive state interventions? What do these choices signify regarding the exercise of prosecutorial discretion? How should we assess the constitutionality of these prosecutorial choices?

1. Press Release, Nat’l Advocates for Pregnant Women, Supreme Court of New Mexico Strikes Down State’s Attempt to Convict Woman Struggling with Addiction During Pregnancy (May 11, 2007), available at http://www.advocatesforpregnantwomen.org/whats_new/victory_in_the_new_mexico_supreme_court_1.php (reporting that, during oral arguments before the Supreme Court of New Mexico, the state’s attorney admitted that the law used to prosecute Cynthia Martinez’s drug addiction during her pregnancy “could potentially be applied to pregnant women who smoked.”).

2. See, e.g., Jane Blood-Siegfried & Elizabeth K. Rende, *The Long-Term Effects of Prenatal Nicotine Exposure on Neurologic Development*, 55 J. MIDWIFERY & WOMEN’S HEALTH 143, 143 (2010) (“Exposure to cigarette smoking is one of the most modifiable causes of morbidity and mortality for both the mother and fetus.”); K.O. Haustein, *Cigarette Smoking, Nicotine and Pregnancy*, 37 INT’L J. CLINICAL PHARMACOLOGY & THERAPEUTICS 417, 417 (1999) (discussing numerous risks of smoking during pregnancy, including higher incidence of spontaneous abortion, premature ablation placentae, physical deformities, and sudden infant death syndrome); Richard L. Naeye, *Influence of Maternal Cigarette Smoking During Pregnancy on Fetal and Childhood Growth*, 57 OBSTETRICS & GYNECOLOGY 18, 20 (1981) (finding that infants of smokers are smaller at birth than infants of nonsmokers).

These questions are important because state statutes are increasingly the primary means through which medical and constitutional norms, including selective invasions of privacy, disclosures of medical information, arrests, prosecutions, and convictions relating to pregnancies are introduced and shaped.³ A recent report issued by Lynn Paltrow, Executive Director of the National Advocates for Pregnant Women (NAPW), and Professor Jeanne Flavin underscores this point. The authors document over four hundred cases from 1973 to 2005 “in which a woman’s pregnancy was a necessary factor leading to attempted and actual deprivations of a woman’s physical liberty.”⁴ Their account of fetal protection interventions on pregnant women adds to the earliest literature in this field, examining the intersections of race and sex in policing women’s reproduction.⁵

Nearly twenty-five years ago, Professor Dorothy Roberts offered a chilling account of government interventions in the pregnancies of low-income, drug-addicted African American women. Roberts exposed race as an intrinsic and entrenched aspect of fetal protection prosecutions in the United States during the late 1980s and early 1990s.⁶ She explained that state intrusions on the pregnancies of poor women of color “are particularly harsh” because these women “are the least likely to obtain adequate prenatal care, the most vulnerable to government monitoring, and the least able to conform to the white, middle-class standard of motherhood.”⁷

In the wake of Roberts’s groundbreaking article, other scholars critiqued government intrusions on pregnant women’s liberty, primarily examining state interventions in drug-addicted women’s reproduction.⁸ Nearly a decade ago,

3. See, e.g., Michelle Goldberg, *Policing Pregnancy*, THE NATION, May 9, 2011, <http://www.thenation.com/article/160092/policing-pregnancy> (noting that “women in several states . . . face[d] arrest and imprisonment for the crime of ending their pregnancies, or merely attempting to do so” under the feticide laws in existence at the federal level and in thirty-eight states).

4. Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women’s Legal Status and Public Health*, 38 J. HEALTH POL. POL’Y & L. 299, 300 (2013) (noting that their study may be an undercount of the instances where pregnant women’s liberty has been subjected to liberty deprivations).

5. Dorothy Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419 (1991).

6. *Id.* at 1421 n.6 (citing an American Civil Liberties Union (ACLU) Reproductive Freedom Project memorandum that identified over 60 percent of the women charged for delivering illicit drugs to their babies were African American); see also Emily Figdor & Lisa Kaeser, *Concerns Mount over Punitive Approaches to Substance Abuse Among Pregnant Women*, 1 GUTTMACHER REP. ON PUB. POL’Y, Oct. 1998, at 3, 4 (“while black women have higher rates of illicit drug use, most women who use illegal drugs during pregnancy are white. Yet, of the 42 women arrested in Charleston . . . 41 were black.”); Gina Kolata, *Bias Seen Against Pregnant Addicts*, N.Y. TIMES, July 20, 1990, at A13 (“In large part, experts said, poor women are more likely to be prosecuted because public hospitals, where poor women go for care, are most vigilant in their drug testing and more likely than private hospitals to report women whose tests show drug use.”).

7. Roberts, *supra* note 5, at 1422.

8. See e.g., SUSAN C. BOYD, *MOTHERS AND ILLICIT DRUGS: TRANSCENDING THE MYTHS* (1999); LAURA E. GÓMEZ, *MISCONCEIVING MOTHERS: LEGISLATORS, PROSECUTORS, AND THE*

Professor Linda Fentiman introduced an economic analysis to the field, arguing that pregnancy interventions are a poor response to inadequate health care for low-income children and their mothers, particularly because they undermine women's ability to fully participate in the economic growth of their families and the nation.⁹ Professor April L. Cherry advanced a novel Free Exercise Clause critique, explaining that courts' dismissals of pregnant women's religious liberty claims are "particularly disrespectful of religious minorities and inappropriate if the free exercise clause is to have any meaning in the lives of those whose faith guides them in these matters."¹⁰ In a subsequent article, Professor Cherry issued a feminist critique, positing that fetal protection efforts reduced pregnant women to "fetal containers" and "maternal environments."¹¹ Professor Michelle Oberman, a prominent health law scholar, examined fetal protection as a conflict not exclusively between mothers and fetuses, but instead between pregnant patients and medical providers.¹² More recently, Professor Julie Cantor explained that forcing women to accept medical interventions on behalf of fetuses belies legal tradition that makes clear that citizens, including parents, "have no legal duty to use their bodies to save one another."¹³ Cantor offers a duty-to-rescue analysis that brings reflections from abortion debates to fetal protection analysis. Nor are proponents of fetal protection silent on this issue, particularly in light of allegations that fetuses experience pain, which has produced symbolic victories (if technical defeats) in the personhood movement.¹⁴

POLITICS OF PRENATAL DRUG EXPOSURE (1997); Julie D. Cantor, *Court-Ordered Care: A Complication of Pregnancy to Avoid*, 366 NEW ENG. J. MED. 2237, 2240 (2012) (analyzing the various approaches courts take in considering whether to intervene in women's pregnancies, concluding that judicial interventions "betray foundational legal principles of our free society, they endanger the liberty of us all."); April L. Cherry, *The Detention, Confinement, and Incarceration of Pregnant Women for the Benefit of Fetal Health*, 16 COLUM. J. GENDER & L. 147 (2007); Linda Fentiman, *Pursuing the Perfect Mother: Why America's Criminalization of Maternal Substance Abuse Is Not the Answer—A Comparative Legal Analysis*, 15 MICH. J. GENDER & L. 389 (2009).

9. Linda C. Fentiman, *The New "Fetal Protection": The Wrong Answer to the Crisis of Inadequate Health Care for Women and Children*, 84 DENV. U.L. REV. 537, 540 (2006) (among other critiques of fetal protection, Fentiman argues these efforts "threaten[] to limit women's ability to participate in the workforce and control their reproductive capability by raising the specter of civil or criminal liability if they engage in potentially risky activities before or during pregnancy . . .").

10. April L. Cherry, *The Free Exercise Rights of Pregnant Women Who Refuse Medical Treatment*, 69 TENN. L. REV. 563, 566–67 (2002) (noting a lack of legal scholarship that acknowledges religious liberty claims as vital, relevant claims to challenge fetal protection interventions).

11. Cherry, *supra* note 8, at 148 (2007) (citing obstetrical literature in the 1980s that increasingly framed gestation as "maternal environments.").

12. Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U.L. REV. 453, 454 (1999–2000).

13. Cantor, *supra* note 8, at 2238, 2240 (2012) (analyzing the various approaches courts take in considering whether to intervene in women's pregnancies, and concluding that judicial interventions "betray foundational legal principles of our free society . . . [and] endanger the liberty of us all.").

14. Very recently, proposed legislation, which recognizes fetal pain and limits abortion access to twenty weeks gestation, introduced a new facet to the debate about fetal rights and personhood. In

This Article does not reiterate the theoretical arguments advanced in prior scholarship. Rather, it argues that legislative fetal protection efforts are on the rise, driving the creation, enactment, and enforcement of statutes authorizing criminal intervention in women's pregnancies. These statutes dramatically exceed prior limits, extending beyond penalizing poor African American pregnant women for illicit drug use, particularly crystallized cocaine (crack). Contemporary fetal protectionism includes sanctioning women for refusing cesarean sections, forcibly confining them to bed rest, and instigating prosecutions for otherwise legal conduct. Frequently class matters as much as race, meaning African American and Latina women no longer serve as the default targets of fetal protection laws, which scholars and activists persuasively demonstrated a quarter-century ago.¹⁵ Over sixty prosecutions in Alabama of poor pregnant women (many of whom are white) in the past few years signify an eerie return to the eugenics-era past.

2012, the U.S. House of Representatives' Subcommittee on the Constitution and Civil Justice held a hearing on fetal pain. Speaking in favor of the District of Columbia Pain-Capable Unborn Child Protection Act (H.R. 3803), Professor Colleen Malloy testified that "[w]ith our advanced 'views into the womb,' we are now able to appreciate the active life of the developing fetus as one who is engaged with his or her uterine locale." *Hearing Before the Subcomm. on the Const. & Civ. Just. of the H. Comm. on the Judiciary*, 112th Cong. 3 (2012) (statement of Colleen A. Mallory, M.D.), available at <http://www.nrlc.org/uploads/fetalspain/TestimonyColleenMalloyHR3803.pdf> (arguing that "fetal pain is no less than the . . . adult pain experience."); Theresa Stanton Collett, *Fetal Pain Legislation: Is It Viable?*, 30 PEPP. L. REV. 161 (2003) (urging the legislative protection of fetuses from pain); Erik Eckholm, *Theory on Pain Is Driving Rules for Abortions*, N.Y. TIMES, Aug. 1, 2013 (reporting on "a push to ban abortion at 20 weeks after conception, on the theory that the fetus can feel pain at that point").

Fetal pain discourse only recently gained significant public attention, despite three decades of debate within the scientific community. Two decades ago, Professor Vincent Collins, along with two dozen professors and physicians, wrote to President Ronald Reagan publicly congratulating him for bringing the term "fetal pain" to the fore. Letter from Vincent Collins et al., Professor of Anesthesiology, Northwestern University, University of Illinois Medical Center, to Ronald Reagan, President (Feb. 13, 1984) ("That the unborn, the prematurely born, and the newborn of the human species is a highly complex, sentient, functioning, individual organism is established scientific fact.").

For a review of the literature advocating recognition of fetal personhood, see Patricia A. King, *The Juridical Status of the Fetus: A Proposal for Legal Protection of the Unborn*, 77 MICH. L. REV. 1647 (1979); Jeffrey Parness & Susan Pritchard, *To Be or Not to Be: Protecting the Unborn's Potentiality of Life*, 51 U. CIN. L. REV. 257 (1982) (arguing that with the exception of the Supreme Court denying fetuses personhood in *Roe v. Wade*, "the unborn are persons under most inheritance and trust law."); Janet Stitch, *Recovery For The Wrongful Death Of a Viable Fetus: Werling v. Sandy*, 19 AKRON L. REV. 127 (1985) ("the rationale used to extend recovery to the viable fetus should be considered with respect to the non-viable fetus to ensure legal protection whenever a wrongful act has been committed.").

15. LYNN PALTROW, CRIMINAL PROSECUTIONS AGAINST PREGNANT WOMEN: NATIONAL UPDATE AND OVERVIEW (1992) (listing the racial identification of pregnant women subjected to state intervention, and finding that the majority were African American); Roberts, *supra* note 5, at 1421 n.6 (noting that the majority of women targeted for state criminal prosecution, because of drug use during pregnancy, "are poor and Black."); Gina Kolata, *Bias Seen Against Pregnant Addicts*, N.Y. TIMES, July 20, 1990, at A13 (citing an ACLU study that found 80 percent of the women targeted for criminal intervention for drug use during pregnancy were African American, Latina, and "members of other minorities.").

This Article analyzes these issues and argues that fetal protection laws and broader efforts to arbitrate women's pregnancies not only violate professional medical ethics and norms, but also emerge from constitutionally suspect judgments about pregnant women. This Article adopts the term "fetal protection laws" (FPLs) to refer to an array of legislation that purports to promote the protection of fetuses. Such legislation includes feticide laws,¹⁶ drug policies,¹⁷ statutes criminalizing maternal conduct,¹⁸ and statutes authorizing the confinement of pregnant women to protect the health of fetuses.¹⁹ In some instances, prosecutors interpret existing laws intended to protect children from physical abuse to apply to fetuses—and thus these applications also fall within the category of fetal protection laws.²⁰ According to proponents, fetal protection laws are intended to promote the health and safety of fetuses by criminalizing actual or intended harm to the unborn.²¹

However, historically, the common law predicated fetal harms such as manslaughter and murder of an infant on an actual birth and the fact that the child was alive at the time the criminal act occurred in order for an individual to be convicted under state law for causing injury to a child.²² Contemporary fetal protection efforts ignore not only this history, but also the wisdom for it. At the time of Professor Roberts's iconic article, prosecutors engaged in artful legal maneuvering to convince courts that existing child abuse statutes should apply to fetuses.²³ Legislatures have since remedied what they perceived as a

16. See, e.g., ALA. CODE § 13A-6-1 (2006); ARIZ. REV. STAT. ANN. § 13-1102-05 (2009); FLA. STAT. ANN. 782.09 (West 2005); MISS. CODE ANN. § 97-3-19 (2013).

17. See, e.g., ALA. CODE § 26-15-3.2 (2006). The term "child" as used in this statute has been interpreted to encompass fetuses. *Ex parte Ankrom*, No. 1110176, 2013 WL 135748, at *11 (Ala. Jan. 13, 2013).

18. These laws are illustrated by those criminalizing drug delivery to a fetus. See ALA. CODE § 26-15-3.2 (2006).

19. WIS. STAT. ANN. § 48.133 (West 2013) (granting the court "exclusive original jurisdiction" over an unborn child in need of protection when the expectant mother "habitually lacks self-control in the use of alcohol beverages, controlled substances . . ."). The Wisconsin law allowed State authorities to incarcerate Alicia Beltran, who was fourteen weeks pregnant, after she told a health care provider about a past (but not current) pill addiction. Erik Eckholm, *Case Explores Rights of Fetus Versus Mother*, N.Y. TIMES, Oct. 24, 2013, at A1 [hereinafter Eckholm, *Fetus versus Mother*].

20. See, e.g., *Whitner v. State*, 492 S.E.2d 777, 780 (S.C. 1997) (holding that a viable fetus is a "child" within the meaning of the state's child abuse and endangerment laws).

21. For a discussion of the underlying legal theories behind these laws, see Paltrow & Flavin, *supra* note 4, at 322–26. See also Kenneth A. De Ville & Loretta M. Kopelman, *Fetal Protection in Wisconsin's Revised Child Abuse Law: Right Goal, Wrong Remedy*, 27 J.L. MED. & ETHICS 332, 332 (1999) (discussing laws in Wisconsin and South Dakota allowing confinement of pregnant women who abuse drugs or alcohol and how they are motivated by "the state's interest in promoting the health of future citizens").

22. *State v. Osmus*, 276 P.2d 469, 476 (Wyo. 1954) (stating that to convict a defendant of infanticide, it must be shown "first, that the infant was born alive, and second, if the infant was born alive that death was caused by the criminal agency of the accused").

23. See Dorothy Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV., 1419, 1420–21 (1991) (recounting the prosecution of Jennifer Clarise Johnson—the first woman in the United States convicted of "exposing

fatal gap in the law, which excluded the “unborn” from protections afforded children.

For example, in Alabama, House Bill 19 (enacted July 1, 2006) revised section 13A-6-1 of the Code of Alabama to include “an unborn child in utero at any stage of development, regardless of viability” as a “person” and “human being” as related to state criminal laws referencing manslaughter, criminally negligent homicide, murder, and assault.²⁴ In 2013, the Alabama Supreme Court further expanded fetal rights in that state by interpreting the term “child” as used in section 26-15-3.2, Alabama Code 197 (commonly referred to as “the Chemical Endangerment Statute”), to include both viable and nonviable fetuses.²⁵ The Alabama Supreme Court recently upheld this ruling in *Ex parte Ankrom*—finding that it was illegal under the statute not only for a pregnant woman to ingest illicit substances, but also to even enter locations where such substances are manufactured or sold.²⁶ Similarly, in Arizona, SB 1052 (enacted April 25, 2005) amended several state statutes²⁷ to grant viable and nonviable fetuses the status of minors less than twelve years of age for purposes of determining criminal sentencing in murder and manslaughter cases.²⁸ In recent years, other states have enacted comparable legislation.²⁹

her baby to drugs while pregnant”—and noting that the prosecution “invented a novel interpretation of the statute”).

24. ALA. CODE § 13A-6-1 (2006). The National Right to Life trumpets these laws as victories for the unborn. *State Homicide Laws That Recognize Unborn Victims*, NAT’L RIGHT TO LIFE (July 5, 2012), <https://www.nrlc.org/federal/unbornvictims/statehomicidelaws092302/>.

25. *Ex parte Ankrom*, No. 1110176, 2013 WL 135748, at *22 (Ala. Jan. 13, 2013) (Parker, J., concurring) (concluding, “the decision of this Court today is in keeping with the widespread legal recognition that unborn children are persons with rights that should be protected by law.”).

26. *Id.* at *15 (reasoning that the word “environment” includes situations in which a person lives and can refer to “an unborn child’s existence within its mother’s womb”). The Alabama statute provides that “a responsible person commits the crime of chemical endangerment of exposing a child to an *environment* in which he or she . . . knowingly, recklessly, or intentionally causes or permits a child to be exposed to, to ingest or inhale, or to have contact with a control substance, chemical substance, or drug paraphernalia . . .”). ALA. CODE § 26-15-3.2 (2006) (emphasis added). Because the court held that the term “child” included unborn children, exposing a fetus to an environment where controlled substances are present could be considered child endangerment. *Ex parte Ankrom*, No. 1110176 at *15.

27. ARIZ. REV. STAT. ANN. §§ 13-604, 13-604.01, 13-703, 13-1102, 13-1103, 13-1104, 13-1105, 13-4062, 31-412, 41-1604.11, 41-1604.13 (2009).

28. *See id.*

29. In Florida, Florida Statute § 782.09, otherwise known as “the Killing Of Unborn Quick Child By Injury To Mother Law,” expanded criminal laws to include the unlawful killing of a fetus or an “unborn quick child” as murder in the same degree “as if committed against the mother.” FLA. STAT. ANN. § 782.09 (West 2005). Other provisions of the law created new crimes to include the killing of a fetus as manslaughter, and extended punishment to vehicular homicide, FLA. STAT. ANN. § 782.071 (West 2001), and DUI manslaughter, FLA. STAT. ANN. § 316.192 (West 2010). It is worth noting that at the time of enactment, the Florida law carved out an exception for abortion and prosecuting pregnant women. *Id.* Recently, however, Florida and other state legislatures have turned to personhood legislation to expand fetal protection even against pregnant women. *See id.*

Personhood referenda mark another significant phenomenon in the advancement of fetal protection efforts. Personhood legislation mandates granting born status and rights to fetuses and

More alarmingly, medical personnel play an increasingly central role in implementing FPLs. This recent era of maternal policing, in addition to inspiring (and sometimes requiring) medical officials to breach their duty of confidentiality in the treatment of pregnant women,³⁰ reshapes police interaction with pregnant women accused of crimes, motivates selective

sometimes embryos, including nonviable ones, contradicting the framework of prevailing constitutional law. For example, the North Dakota Senate and House passed the Inalienable Right to Life of Every Human Being at Every Stage of Development law in 2013, granting embryos and conceivably pre-embryos “inalienable” rights. S. Con. Res. 4009, 63rd Leg. Assemb., Reg. Sess. (N.D. 2013). The law now awaits a popular ballot vote in 2014. This legislation, the first such law to pass both the Senate and House of a state, requires that “the inalienable right to life of every human being at any stage of development must be recognized and protected.” *Id.* In an interview, Senator Margaret Sitte, sponsor of North Dakota’s personhood law, suggested that countering *Roe v. Wade* was the purpose of her legislation. She explained, “We are intending that it be a direct challenge to *Roe v. Wade*, since Scalia said that the Supreme Court is waiting for states to raise a case.” Laura Bassett, *North Dakota Personhood Measure Passes State Senate*, HUFFINGTON POST (Feb. 7, 2013, 5:24 PM), http://www.huffingtonpost.com/2013/02/07/north-dakota-personhood_n_2640380.html.

Obvious maternal fetal conflicts extending beyond abortion are implicated and realistically in tension with such laws, including the risk that honoring embryo life could undermine maternal health and risk maternal death or lead to the possible criminalization of otherwise legal behavior during pregnancy. See Marcia Angell & Michael Greene, Op-Ed., *Where are the Doctors?*, USA TODAY (May 15, 2012, 6:36 PM), <http://www.usatoday.com/news/opinion/forum/story/2012-05-15/women-contraception-abortion-reproductive-rights-doctors/54979766/1>. That these measures are gaining momentum is evidenced by the broad number of states taking up personhood legislation—even when such measures ultimately fail at the ballot box. See *id.* Thus, referenda in Mississippi and Colorado and petitions in Florida, Georgia, Nevada, Ohio, Montana, California, Kansas, Virginia, Alabama, and other states to redefine “personhood” mark only the most recent manifestations of legislative fetal protection efforts. And although these personhood amendments have so far failed, the arrests, prosecutions, and involuntary “maternity rest” restraining orders obtained against pregnant women under other extant state and federal laws evidence that such fetal protection efforts are more than an isolated, fringe legislative movement. A comprehensive summary of state statutes and cases is on file with the author. For a discussion of recent legislation restricting reproductive rights, see Marcia Angell & Michael Greene, Op-Ed., *Where are the Doctors?*, USA TODAY (May 15, 2012, 6:36 PM), <http://www.usatoday.com/news/opinion/forum/story/2012-05-15/women-contraception-abortion-reproductive-rights-doctors/54979766/1>; see also *Monthly State Update: Major Developments in 2014*, GUTTMACCHER INST. (Apr. 1, 2014), <http://www.guttmacher.org/statecenter/updates/index.html>; *2011 Ballot Measures: Election Results*, NAT’L CONF. STATE LEG. (Nov. 9, 2011, 7:45 AM), <http://www.ncsl.org/legislatures-elections/elections/ballot-measure-election-results.aspx>; Keith Ashley, *Voters in the Georgia GOP Primary Will Vote on Personhood*, PERSONHOOD USA (May 22, 2012), <http://cm.personhoodusa.com/voters-georgia-gop-primary-will-vote-personhood>; Eckholm, *Fetus versus Mother*, *supra* note 19; Julie Rovner, *Abortion Foes Push to Redefine Personhood*, NAT’L PUB. RADIO (June 1, 2011), <http://www.npr.org/2011/06/01/136850622/abortion-foes-push-to-redefine-personhood>; Grace Wyler, *Personhood Movement Continues to Divide Pro-Life Activists*, TIME, July 24, 2013, available at <http://nation.time.com/2013/07/24/personhood-movement-continues-to-divide-pro-life-activists/> (discussing efforts by Wisconsin Republicans to enact a personhood amendment granting human embryos the same civil rights as people).

30. See Angell & Greene, *supra* note 29 (noting that recent legislative restrictions on reproductive freedom work “mainly by intruding on the relationship between doctor and patient”). *Ferguson v. City of Charleston* illustrates such a policy, which required doctors and nurses to report pregnant women’s drug test results to police without the women’s knowledge. 532 U.S. 67, 83–86 (2001) (holding that a state hospital’s performance of a diagnostic test to obtain evidence of a patient’s criminal conduct for law enforcement purposes is an unreasonable search if the patient has not consented to the procedure).

prosecution,³¹ and obligates judges to make poor judgment calls.³² So far, thirty-eight states have implemented feticide statutes, a particularly worrying species of fetal protection laws.³³

*Regina v. Knight*³⁴ is one of the earliest reported cases involving the manslaughter prosecution of a woman for failing to protect her fetus. Upon hearing compelling evidence leading to the “conclusion that the child had been born alive, and had died by the hands of the mother,” the Chief Justice reasoned that even under those circumstances the mother could not be guilty of manslaughter as there was no basis in law or doctrine for such a prosecution.³⁵ Generally, in utero harms did not serve as the basis for child abuse, manslaughter, or murder convictions, particularly because proximate causation could not be established due to remoteness.³⁶ Moreover, the legal presumption of life was rooted at birth, not conception.³⁷ In essence, the crime of fetal abuse did not exist prior to contemporary legislative efforts. As the case *Rex v. Izod*³⁸ demonstrated a century ago, a woman’s manslaughter conviction in the death of her child required a showing of criminal “neglect after the child has been completely born.”³⁹ In that case, a widow’s failure to provide care to her fetus during labor and post-birth was evidence of negligence and serious neglect, but

31. See Linda C. Fentiman, *In the Name of Fetal Protection: Why American Prosecutors Pursue Pregnant Drug Users (And Other Countries Don't)*, 18 COLUM. J. GENDER & L. 647, 669 (2009) (“The criminal prosecution of pregnant women for causing fetal harm exemplifies the . . . dangers of the American system of autonomous state prosecutors. Locally elected, politically ambitious, and largely unsupervised, individual prosecutors have wide discretion in deciding whether, when, and whom to prosecute.”).

32. *In re A.C.*, 533 A.2d 611, 617 (D.C. 1987), *vacated*, 573 A.2d 1235 (D.C. 1990) (upholding a court-ordered cesarean section of a terminally ill pregnant woman and concluding that the trial court judge “did not err in subordinating A.C.’s right against bodily intrusion to the interests of the unborn child and the state”); *In re Unborn Child of Samantha Burton*, No. 2009 CA 1167, 2009 WL 8628562 (Fla. Cir. Ct. Mar. 27, 2009) (granting an order authorizing Tallahassee Memorial HealthCare to provide “medically necessary” treatment “to preserve the life and health of Samantha Burton’s unborn child,” including involuntary bed rest).

33. See *Fetal Homicide Laws*, NAT’L CONF. STATE LEGISLATURES, <http://www.ncsl.org/issues-research/health/fetal-homicide-state-laws.aspx> (updated Feb. 2013).

34. *R. v. Knight*, (1860) 2 F. & F. 46.

35. Ironically, the defendant was “eventually found guilty of concealing” the childbirth and sentenced to twenty-four months of hard labor. *Regina v. Knight*, *Rex v. Izod*, and *State v. Osmus* present troubling facts: they each involve poor women who at delivery passively allow their infants to expire. In at least one case, it appears the woman may have taken affirmative steps to end the life of the infant. Yet, in each instance, the courts take great strides to clarify that the crime of manslaughter does not apply to the women’s failures to provide appropriate prenatal, labor, and postnatal care, even when it contributes to fetal harm or infant death. *State v. Osmus*, 276 P.2d 469 (Wyo. 1954); *R. v. Izod*, (1904) 20 Cox CC 690; *R. v. Knight*, (1860) 2 F. & F. 46.

36. See *Izod*, 20 Cox CC at 691 (reasoning that although a woman may be guilty of neglect for failing to care for her fetus, the neglect “is not enough to justify a verdict of manslaughter” if the neglect is confined to the time the child is in utero).

37. See *id.* at 691 (holding that “a child must be completely born before it can be the subject of an indictment for either murder or manslaughter.”) (emphasis added). This suggests that until a child is “completely born,” it is not considered a legal entity for purposes of murder or manslaughter.

38. *Id.*

39. *Id.* at 691.

not manslaughter, because there was no finding of “neglect of the child itself treated as a separate being.”⁴⁰

In 1954, the Wyoming Supreme Court cited *Rex v. Izod* when it overturned the manslaughter conviction of Darlene Osmus in her newborn’s death.⁴¹ In rejecting the state’s two central contentions that Osmus was guilty of nonfeasance under Wyoming’s child abuse and neglect statute⁴² and manslaughter for failure to obtain prenatal and delivery care,⁴³ Justice Blume emphasized that the law “relate[d] to a really living child.”⁴⁴ The court stressed that “one of the questions is as to whether or not the child was born alive.”⁴⁵ According to the court, the law did “not directly provide or even intimate that it applies to a child[,] such as involved in this case,”⁴⁶ which contracted severe pneumonia shortly after birth.⁴⁷

By contrast, contemporary fetal protection efforts mark a dramatic departure from the criminal jurisprudence a century prior because they adopt the legal standard that fetuses are persons. Under this standard, viability and the capacity to live outside of the womb are neither necessary nor relevant. This shift in law is significant as it normalizes treating the unborn as if they were born and alive at the time of injury, which not only implicates abortion policy, but also criminal law and women’s other constitutional interests.

40. *Id.*

41. Darlene Osmos was a twenty-year-old unmarried woman who claimed she did not know she was pregnant when she went into labor and gave birth to the infant in the bathroom late one night. *Osmus*, 276 P.2d at 470–71. She testified that the infant was born dead, and that she had not informed anyone of the situation. *Id.* Three days later, she left the infant’s body on the side of the highway. She was accused of murder, found guilty of manslaughter, and sentenced to two to four years in prison. *Id.*

42. WYO. STAT. ANN. § 58-101 (1945). The statute in question reads: “It shall be unlawful for any person having or being charged by law with the care or custody or control of any child under the age of nineteen (19) years knowingly to cause or permit the life of such child to be endangered or the health or morals or welfare of such child to be endangered or injured, or knowingly to cause or permit such child to be in any situation or environment such that the life, health, morals, or welfare of such child will or may be injured or endangered, or willfully or unnecessarily to expose to the inclemency of the weather, or negligently or knowingly abandon or fail to provide the necessities of life for such child, or to ill-treat, abuse, overwork, torture, torment, cruelly punish such a child, or to negligently or knowingly deprive or fail to furnish necessary food, clothing or shelter for such child, or in any other manner injure said child.”

43. Justice Blume explained, “[S]uch nonfeasance must, of course, have occurred prior to the birth of the child and hence has no possible connection with [the law] so that an instruction setting out that section was error again in the light of that theory.” *Osmus*, 276 P.2d at 475.

44. *Id.* at 474.

45. *Id.*

46. *Id.*

47. *Id.* at 472. The Wyoming Supreme Court further explained that the establishment of guilt in such cases requires direct and immediate causation, noting that the court does not consider a remote cause as an efficient or proximate cause. Blume opined, “A cause must be the efficient, commonly called the proximate, cause or it is not a cause at all in law. That is the rule in the law of torts and we see no reason why it should not apply here.” *Id.* at 474. *But see People v. Chavez*, 176 P.2d 92, 94 (Cal. Dist. Ct. App. 1947) (holding that a viable fetus in the process of birth is a human being within the meaning of homicide statutes even when the birth is not fully complete).

For women subject to contemporary fetal protection laws, the consequences can be extraordinarily harsh. In July 2013, Alicia Beltran was arrested, shackled, and confined by court order to a drug treatment center for seventy-eight days after she refused a doctor's orders to take a potentially dangerous opiate blocker.⁴⁸ During a prenatal checkup, Beltran had confided to medical staff that she previously battled an addiction to opiates but managed to overcome drug dependency. She revealed that before becoming aware of her pregnancy, she ingested a single Vicodin tablet for pain.⁴⁹ Christine Taylor was arrested in 2010 for falling down a set of stairs in her Iowa home.⁵⁰ Hospital staff reported Taylor to police after interpreting the fall as attempted feticide.⁵¹ Melissa Rowland's reluctance to submit to an immediate cesarean section prompted medical personnel in Utah to urge her arrest.⁵² She was subsequently charged with murder for the stillbirth of one of her fetuses.⁵³ In Florida, a state court authorized Samantha Burton's involuntary confinement because she refused bed rest against her physician's recommendation.⁵⁴ Several days after her hospital incarceration, Burton suffered a miscarriage, alone in a dreary, gray hospital room that, according to her lawyer, resembled a jail cell.⁵⁵ As these examples illustrate, nurses and doctors often act as interpreters of state law, framing the described events as volitional, criminal acts against developing fetuses, and therefore against the broader community and the state.⁵⁶

State legislation criminalizing pregnant women's unhealthy—but otherwise legal—conduct, such as ignoring doctors' recommendations or

48. See Eckholm, *Fetus versus Mother*, *supra* note 29.

49. *Id.*

50. Kevin Hayes, *Did Christine Taylor Take Abortion Into Her Own Hands?*, CBS NEWS (Mar. 2, 2010, 6:55 AM), <http://www.cbsnews.com/news/did-christine-taylor-take-abortion-into-her-own-hands/>.

51. *Id.*

52. Alexandria Sage, *Mother Denies Murder Charges*, L.A. TIMES, Mar. 14, 2004, at A26.

53. *Id.* The state ultimately dropped the murder charge and Rowland pled guilty to child endangerment. *Mother Who Avoided C-Section Gets Probation*, L.A. TIMES, Apr. 30, 2004, at A13.

54. Susan Donaldson James, *Pregnant Woman Fights Court-Ordered Bed Rest*, ABC NEWS (Jan. 14, 2010), http://abcnews.go.com/Health/florida-court-orders-pregnant-woman-bed-rest-medical/story?id=9561460#.UB_djfvQgcu.

55. *Id.*

56. See HENRY SUMNER MAINE, *ANCIENT LAW: ITS CONNECTION WITH THE EARLY HISTORY OF SOCIETY, AND ITS RELATION TO MODERN IDEAS* 372 (New York, Charles Scribner 1864) (“[T]he conception of *Crime* . . . involves the idea of injury to the State or collective community.”); Dorothy E. Roberts, *Unshackling Black Motherhood*, 95 MICH. L. REV. 938, 941 (1997); Charles Condon, *Clinton's Cocaine Babies: Why Won't the Administration Let Us Save Our Children*, 72 POL'Y REV. 12 (1995) (arguing that in his former capacity as circuit solicitor of South Carolina, “[w]e needed a program that used not only a carrot, but a real and very firm stick.”), available at <http://www.hoover.org/publications/policy-review/article/6853>; see also Brief of Respondents City of Charleston, SC et al. at 25, *Ferguson v. Charleston*, 532 U.S. 67 (2001) (No. 99-936) (stating that “medical communities in the City of Charleston, other areas of the State of South Carolina, and across this Nation” experienced “serious maternal and neonatal health problems as a result of the epidemic of prenatal drug abuse”);

falling down steps, reinvigorates old, but clearly unsettled, reproductive policy debates related to maternal responsibility, autonomy, and privacy.⁵⁷ Proponents of FPLs typically point to pregnant drug addicts as the targets of their legislative efforts because they are unsympathetic;⁵⁸ other pregnant women like Taylor, Rowland, and Burton are simply collateral damage. Texas Representative Doug Miller's statement of support for fetal protection legislation illustrates this special solicitude: "I am interested in providing additional safety and protection for our next generation, and it must happen now The Texas Legislature can no longer sit idly by while its next generation is born addicted to illegal drugs, born with physical and mental abnormalities, set up for educational hardship, and destined to be on Social Security benefits. Parents must be responsible for their actions."⁵⁹

Yet the symbolic walls proponents erect—distinguishing the illicit drug user from all other pregnant women—deserve scrutiny. On inspection some of the distinctions between these cohorts are quite arbitrary. For example, studies

57. See, e.g., Mary Becker, *From Muller v. Oregon to Fetal Vulnerability Policies*, 53 U. CHI. L. REV. 1219 (1986) (critiquing fetal vulnerability policies in the workplace); Marianne N. Prout & Susan S. Fish, *Participation of Women in Clinical Trials of Drug Therapies: A Context for the Controversies*, MEDSCAPE WOMEN'S HEALTH, Oct. 2001, at 3, available at <http://www.medscape.com/viewarticle/408956> (illustrating the political debate over pregnant women's clinical research participation in its discussion of a revised regulation that was issued during the Clinton administration and was intended to enhance pregnant women's participation in clinical research, but was delayed by a directive from President George W. Bush); Joanne Cavanaugh, *Pregnant Pause*, JOHNS HOPKINS MAG., Sept. 2001, <http://www.jhu.edu/~jhumag/0901web/pregnant.html> (stating that debates about pregnant women's participation in clinical drug trials "touches one of the most emotional debates of our time: the right of a woman to make her own health care decisions vs. views that a fetus has rights and is vulnerable because it can't give consent to experimental treatment."); see also *U.S. Military Drops Ban on Soldiers Getting Pregnant*, CNN (Dec. 25, 2009, 8:55 AM), <http://www.cnn.com/2009/WORLD/meast/12/25/iraq.us.soldiers.pregnant/> (discussing the U.S. military's repeal of a "controversial rule that called for punishing soldiers in northern Iraq for becoming pregnant or impregnating another soldier"). The rule was created by Major General Anthony Cucolo, who designed it to make soldiers "think before they act." Under Major General Cucolo's command, four pregnant women were given letters of reprimand and sent back to the United States. *Id.*

58. See, e.g., Condon, *supra* note 56 (stating that cocaine-using pregnant women "knowingly cause neurological damage to their unborn children" and that without legal recourse, health care providers must sit by and "watch them destroy a baby"); Sofia Resnick, *Texas Proposed Law Could Jail Women for Taking Drugs During Pregnancy*, AM. INDEP. (Feb. 24, 2011), americanindependent.com/171004/texas-proposed-law-could-jail-women-for-taking-drugs-during-pregnancy (quoting Texas Rep. Doug Miller speaking about the bill he sponsored that would have made it a state felony offense for a woman to ingest controlled substances during her pregnancy). Barbara Harris, founder of Project Prevention, formerly known as Children Requiring a Caring Community (CRACK), pushes an equally caustic message in news interviews and on billboards and posters that feature statements such as "Don't let a pregnancy ruin your drug habit." Harris is a staunch advocate of aggressive criminal law reform and sterilization targeting drug addicts. Her organization pays drug addicts to undergo sterilization procedures. See Rheana Murray, *Group Pays Drug Addicts to Get Sterilized or Receive Long-Term Birth Control, Sparks Criticism*, N.Y. DAILY NEWS (May 9, 2012, 10:31PM), <http://www.nydailynews.com/life-style/health/group-pays-drug-addicts-sterilized-receive-long-term-birth-control-sparks-criticism-article-1.1075432#ixzz2pNjd4zAX>.

59. Resnick, *supra* note 58 (quoting Rep. Miller).

suggest white women and women with higher levels of education are more likely than others to seek and acquire prescription medications, including Xanax, Oxycontin, Demerol, Ritalin, and Tylenol with codeine during their pregnancies.⁶⁰ These legally obtained prescription drugs may be as harmful to fetuses when taken during pregnancy as illegally obtained prescription or illicit drugs,⁶¹ however, often only the latter drug users are targeted for prosecution.⁶²

This Article argues that FPLs penalize pregnant women for fetal outcomes incidental to maternal control, carving out punishable distinctions between pregnant women's conduct and that of all other groups. FPLs undermine pregnant women's constitutional rights to be treated as equal citizens, to be free from unreasonable searches and seizures, and to be secure in their bodies. This Article demonstrates that fetal protection efforts reveal hostility to the concerns of low-income pregnant women. It argues that, because these laws do very little to promote fetal health, FPLs measure women's obedience and not fetal risk. These laws counterproductively emphasize prosecution and incarceration over patient autonomy and medical treatment, normalizing shaming and stigmatization in poor women's pregnancies. FPLs ignore the fiduciary relationship between physicians and their patients, which should be no less rigorously affirmed and defended than the attorney-client relationship. However, by conscripting doctors as gatekeepers for this type of legislative agenda, policy makers incorrectly presume that health care providers are immune to class and race bias because of their education. Moreover, as cases in

60. COMMITTEE ON HEALTHCARE FOR UNDERSERVED WOMEN, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, COMMITTEE OPINION NO. 538: NONMEDICAL USE OF PRESCRIPTION DRUGS 2 (2012), available at <http://www.acog.org/~media/Committee%20Opinions/Committee%20on%20Health%20Care%20for%20Underserved%20Women/co538.pdf?dmc=1&ts=20140102T1509157316> ("White women are more likely to abuse prescription pain relievers than women of any other race or ethnicity."); Kevin A. Mack et al., *Vital Signs: Overdoses of Prescription Opioid Pain Relievers and Other Drugs Among Women—United States, 1999–2010*, 62 MORBIDITY & MORTALITY WEEKLY REP. 537, 538 (2013) (finding that white women have higher drug overdose death rates than Black women); Allen A. Mitchell et al., *Medication Use During Pregnancy, with Particular Focus on Prescription Drugs: 1976–2008*, 205 AM. J. OBSTETRICS & GYNECOLOGY 51.e1 (2011).

61. See, e.g., Lindsay Tanner, *Pregnant Moms Using Cocaine Has Less Effect on Infants Than Previously Thought, Says Research*, CHRISTIAN SCI. MONITOR (May 30, 2013), <http://www.csmonitor.com/The-Culture/Family/2013/0530/Pregnant-moms-using-cocaine-has-less-effect-on-infants-than-previously-thought-says-research> (noting study's finding that cocaine use in pregnancy is not as associated with harms as was previously believed); *Abusing Prescription Drugs During Pregnancy*, AM. PREGNANCY ASS'N, <http://americanpregnancy.org/pregnancyhealth/abusingprescriptiondrugs.html> (last updated May 2011) (discussing how use of any drug, including prescription drugs, can have harmful consequences, such as birth defects, preterm labor, and low birth weight); *Medications and Pregnancy*, CDC, <http://www.cdc.gov/pregnancy/meds/> (last updated Apr. 15, 2014) (noting that many medications may have adverse effects in pregnancy but that "little information is available about the safety of most medications during pregnancy—including those available over the counter").

62. See generally Michele Goodwin, *Prosecuting the Womb*, 76 GEO. WASH. L. REV. 1657, 1680–82 (2008) (discussing the disparate state involvement and prosecution of different classes of drugs users); Gina Kolata, *Bias Seen Against Pregnant Addicts*, N.Y. TIMES, July 20, 1990, at A13.

this Article attest, doctors do not always judge dispassionately and their clouded judgment may affect judicial enforcement, which is subject to similar pathologies as health care enforcement.

This Article develops in four parts. Part I takes up my claim that fetal protection statutes authorizing criminal intervention in women's pregnancies entrench discriminatory norms. Specifically, this Part shows that, in asking doctors and nurses to police pregnant women's behavior, these moralizing laws become further defined by subjective "decency" standards and interpretations at the ground level, including reliance on stereotypes, and thus prove fallible and discriminatory.

Part II further examines the role of doctors in fetal protection interventions. It analyzes the applicability of bioethics principles to contemporary fetal protection interventions and makes several normative claims: confidentiality is essential to the physician-patient relationship and should not be violated by health care providers; medical treatments should avoid subjecting patients to unnecessary suffering, including, but not limited to, unnecessary reproductive surgeries; and patients must be at liberty to withdraw from medical treatment, even if doing so risks death. Part II concludes by explaining why FPLs are unlikely to achieve medical utility.

Part III considers whether FPLs, despite burdening women's medical and reproductive liberty, pass constitutional muster. It argues that such laws operate at odds with Fourteenth Amendment due process and equal protection values. This Part also advances a normative claim that punitive state interventions in women's pregnancies do not simply reflect the government's interest in protecting fetal health. Instead, it argues that fetal protection efforts reflect suspect judgments about pregnant women generally, and poor pregnant women in particular, because states selectively engage this purported interest. Selective prosecutions and interventions function to discourage and punish some conduct that may threaten fetal health while simultaneously bypassing other fetal-endangering behavior without medical or legal justification. Part III argues that even if states can articulate an important interest in regulating pregnant women's reproductive conduct, the means by which states enforce the legislation may not be substantially related to the states' ultimate goal of protecting fetal health.

I.

IMPLEMENTATION OF STATE LAW: THE SHIFTING ROLE OF MEDICAL PERSONNEL IN FETAL PROTECTION LAW CASES

Nurses and doctors increasingly must interpret and implement state fetal protection laws and implement key statutory provisions.⁶³ More than one-third

63. See GUTTMACHER INST., STATE POLICIES IN BRIEF: SUBSTANCE ABUSE DURING PREGNANCY (2014) (listing states that require health care professionals to report suspected prenatal

of states now consider pregnant women's illicit drug use a form of child abuse,⁶⁴ resulting in unprecedented forms of criminal and civil punishment.⁶⁵ Several states permit civil confinement of pregnant women to protect their fetuses.⁶⁶ Fifteen states mandate doctors and nurses report pregnant women whom they suspect of illicit drug use,⁶⁷ establishing a low and vague threshold of suspicion rather than actual proof.

Health care professionals' reporting obligations arise in part due to the influence of federal legislation. The Keeping Children and Families Safe Act of 2003⁶⁸ mandates that states receiving federal funds for child abuse and neglect services must promulgate regulations *requiring* health care providers involved in the delivery or care of infants "identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug

drug abuse), available at http://www.guttmacher.org/statecenter/spibs/spib_SADP.pdf; see also WISC. STAT. ANN. § 48.133 (West 2013) (granting the court "exclusive original jurisdiction" over an unborn child in need of protection when the expectant mother "habitually lacks self-control in the use of alcohol beverages, controlled substances . . .").

64. The states include: Arkansas, Colorado, Florida, Illinois, Indiana, Iowa, Louisiana, Minnesota, Nevada, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Virginia, and Wisconsin. GUTTMACHER INST., *supra* note 63.

65. That seventeen states consider illicit drug use and dependency to be a form of child abuse is unprecedented even though drug dependency is not a particularly new phenomenon. See *id.* In the early twentieth century legislatures feared a broad scale heroin epidemic among elite white women, including mothers. Stephen R. Kandall, *Women and Addiction in the United States—1850 to 1920*, in DRUG ADDICTION RESEARCH AND THE HEALTH OF WOMEN 33, 34–35, 40, 45–46 (Cora Lee Washington & Adele B. Roman eds., 1998) (discussing the high rates of heroin and opiate use in general among women in the late nineteenth and early twentieth centuries and legislative efforts to curb narcotics sales). Politicians specifically targeted drug trafficking and traffickers for the rise in heroin overdoses and addictions among the elite white women. A century later, the political approach to women's illicit drug use is quite different as are the penalties, which include criminal punishment and civil penalties. Clifford B. Farr, *The Relative Frequency of the Morphine and Heroine Habits*, 101 N.Y. MED. J. 894 (1915) (reporting a 1915 survey at Philadelphia General Hospital that found that 25 percent of heroin addicts were women); Joseph McIver & George E. Price, *Drug Addiction: Analysis of One Hundred and Forty-Seven Cases at the Philadelphia General Hospital*, LXVI JAMA 476, 478 (1916) (discussing how anti-narcotic laws made opiates and heroin more expensive, and thus more difficult to obtain by lower class individuals).

66. MINN. STAT. ANN. § 253B.02 (West 2013) (defining a "chemically dependent person" who can be committed to include a pregnant woman "who has engaged during the pregnancy in habitual or excessive use, for a nonmedical purpose," of alcohol and certain drugs); OKLA. STAT. ANN. tit. 63, § 1-546.5 (West 2000) ("A district attorney may convene a multidisciplinary team to assist in making a determination of the appropriate disposition of a case of a pregnant woman who is abusing or is addicted to drugs or alcohol to the extent that the unborn child is at risk of harm."); S.D. CODIFIED LAWS § 34-20A-63 (allowing "emergency commitment" of an "intoxicated person who . . . [i]s pregnant and abusing alcohol or drugs"); WISC. STAT. ANN. § 48.133 (West 2013).

67. The states are: Alaska, Arizona, Illinois, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Montana, North Dakota, Oklahoma, Rhode Island, Utah, and Virginia. GUTTMACHER INST., *supra* note 63.

68. Pub. L. No. 108–36, 117 Stat. 800 (codified as amended in 42 U.S.C. § 5106a).

exposure” to notify the child protective services system of the exposure.⁶⁹ This is often the first step in police notification.⁷⁰

But what explains health care providers’ decisions to report nondrug related cases or threatening to do so? When Lisa Epstein indicated that she wanted to wait two additional days for a vaginal delivery rather than undergo the cesarean section recommended by Dr. Jerry Yankowitz, chairman of the University of South Florida’s (USF) department of obstetrics and gynecology, he sent the mother of five a threatening email, warning: “I would hate to move to the most extreme option, which is having law enforcement pick you up at your home and bring you in, but you are leaving the providers of USF/TGH no choice.”⁷¹ Epstein knew she had a complicated, high-risk pregnancy⁷² but did not expect the threat or involvement of law enforcement in giving birth. She recounted to a *Tampa Bay Times* reporter fears about “cops on my doorstep taking me away from home—in front of my children—to force me into having surgery.”⁷³ She recounted feeling betrayed, bullied, and abandoned by her doctor.⁷⁴ Eventually, medical staff at USF accommodated Epstein’s request after receiving a letter from National Advocates for Pregnant Women (NAPW), demanding that Yankowitz cease and desist “any further threats or actions against Ms. Epstein.”⁷⁵ Nevertheless, Epstein’s traumatic experience highlights concerns central to this Article, including the fact that fetal protection laws embolden some doctors to threaten criminal punishment even when no crime has been committed.

In their politicized roles as deputized interpreters of the law, physicians and nurses may misinterpret the law or, even worse, prioritize exercising their legal judgment over their medical judgment. In this context, physicians and nurses are called upon to wear two hats: that of health care provider, and that of law enforcer. There are three main reasons conflicts arise when medical personnel act as both health care providers and law enforcers. First, patients’ interests in their health and privacy may become subordinate to physicians’ desires to accommodate or promote state interests. Indeed, physicians and

69. 42 U.S.C. § 5106(a)–(b)(2)(B).

70. In most states, statutes specifying procedures that State agencies must follow in handling reports of suspected child abuse include requirements for “cross-system” reporting and information sharing among social services agencies, law enforcement, and prosecutors. CHILD WELF. INFO. GATEWAY, CROSS-REPORTING AMONG RESPONDERS TO CHILD ABUSE AND NEGLECT (2012), available at https://www.childwelfare.gov/systemwide/laws_policies/statutes/xreporting.pdf. Some states mandate that all initial reports to a child protective services agency must also be cross-reported to the appropriate law enforcement agency. *Id.*

71. Letitia Stein, *USF Obstetrician Threatens to Call Police if Patient Doesn't Report for C-Section*, TAMPA BAY TIMES, Mar. 6, 2013, <http://www.tampabay.com/news/health/usf-obstetrician-threatens-to-call-police-if-patient-doesnt-report-for/2107387>.

72. In fact, her high-risk pregnancy was what led her to Dr. Yankowitz in the first place because he was one of only a few doctors willing to try a vaginal birth after cesarean. *Id.*

73. *Id.*

74. Fortunately for Epstein, she had the capacity and wherewithal to reach out to NAPW. *Id.*

75. *Id.*

nurses may fear civil or criminal punishment for failing to inform on their patients. Second, physicians' legal duties to comply with law enforcement protocols may conflict with their ethical duties to the patient, including maintaining confidentiality and avoiding malfeasance. Third, physicians' obligations to the profession⁷⁶ may conflict with obligations to law enforcement by interfering with physicians' independent medical judgment.⁷⁷ Importantly, in addition to any conflicts of interest that may arise in this context, medical professionals' legal decisions may also be at odds with patients' constitutional rights.⁷⁸

Section A unpacks cases that offer a lens into the phenomenon of medical personnel interpreting fetal protection law. Section B critiques this increased reliance on medical personnel as a problematic delegation of significant discretionary power that has increased the harmful presence of bias and stereotyping in the enforcement of fetal protection laws.

A. States Increasingly Rely on Medical Personnel to Interpret State Statutes

Cases across the United States illustrate how physicians and hospital staff operate not only as caretakers to their patients, but also interpreters of state statutes. States increasingly seek physicians' appraisal of pregnant women's behavior under the guise of promoting fetal health. Substantively, however, state interventions in women's pregnancies seem far more related to evaluating women's compliance and obedience. Indeed, fetal protection efforts expose legislative antagonism to the interests of low-income pregnant women. This Section argues that FPLs are intended to measure women's obedience and not actual fetal risk, since these laws do very little to promote fetal health. The cases described below could be substituted by other examples in Alabama, Maryland,⁷⁹ Mississippi,⁸⁰ South Carolina⁸¹ and other states. Although the

76. Physicians' obligations to the *profession* are not distinct, but complementary to, their obligations to the patient and at times can conflict. See Linda B. Johnston, *Playing Doctor: Who Controls the Practice of Medicine?*, 66 ST. JOHN'S L. REV. 425, 425 n.2 (1992). For example, a physician's interpretation of his duty to "do no harm," an obligation meant to protect the patient and maintain the profession's integrity, may conflict with the patient's best interests, if the patient is asking the doctor to do something that the doctor believes is "harmful" (i.e., physician-assisted suicide, euthanasia).

77. See *id.* ("The nature of medical work has always required independent professional judgment.").

78. As Lynn Paltrow, Executive Director of NAPW, explains, Epstein's experience "raises serious concerns about the misuse of state authority to deprive pregnant women of their constitutional personhood and to endanger the health of women and babies." Press Release, Nat'l Advocates for Pregnant Women, Florida Doctor Threat of Arrest of Pregnant Woman Dangerous and Without Legal Authority (Mar. 6, 2013), available at <http://advocatesforpregnantwomen.org/blog/2013/03/>.

79. *Kilmon v. State*, 905 A.2d 306 (Md. 2006) (reversing a circuit court's finding of reckless endangerment based on use of controlled substances while pregnant).

80. See, e.g., *State v. Buckhalter*, 119 So.3d 1015, 1017, 1019 (Miss. 2013) (affirming the trial court's dismissal of Nina Buckhalter's indictment for manslaughter, which alleged she "willfully" caused her child's death by using drugs during pregnancy and concluding that the indictment was

scope of cases resulting in law enforcement is unknown, Lynn Paltrow estimates that the 413 interventions that she recently documented represent “a substantial undercount.”⁸² However, like similar cases, the accounts below call our attention to a hard reality: obtaining appropriate prenatal care can be subject to state (political) rather than medical (patient-centered) considerations. Moreover, the cases are particularly illustrative of a trend that extends beyond specific geographic regions in the United States.

1. Samantha Burton’s Involuntary Bed Rest

In 2010, during a routine prenatal medical visit, Samantha Burton’s physician ordered bed rest at the hospital for the duration of her pregnancy—when she was only twenty-five weeks pregnant.⁸³ While recommending bed rest to a patient is not unusual,⁸⁴ seeking a court order to enforce it is another matter. Yet, officials at the hospital Burton visited did just that, setting into action a plan to obtain a court order allowing the hospital to confine Burton against her will.⁸⁵ In the process, these officials refused to consider Burton’s protestations for a second opinion, her desire to return home to her two children, or her plea to switch to a different hospital.⁸⁶ Instead, Burton was

“fatally flawed”); Ada Calhoun, *The Criminalization of Bad Mothers*, N.Y. TIMES MAG., Apr. 25, 2012, <http://www.nytimes.com/2012/04/29/magazine/the-criminalization-of-bad-mothers.html?pagewanted=all> (relating the story of Rennie Gibbs, who was charged with “depraved heart murder” after her baby was stillborn and tested positive for cocaine); Emily Le Coz, *Mississippi Stillborn Manslaughter Charge Raising Fears*, USA TODAY (May 29, 2013, 1:01 PM), <http://www.usatoday.com/story/news/nation/2013/05/29/mississippi-stillborn-manslaughter-charge-raising-fears/2369523/> (discussing Buckhalter’s manslaughter trial for the loss of her fetus, which prosecutors claimed was caused by her illegal drug use).

81. See, e.g., *Ferguson v. Charleston*, 532 U.S. 67 (2001) (concluding that a state hospital’s policy requiring diagnostic tests to obtain evidence of a pregnant woman’s drug use for law enforcement purposes constitutes an “unreasonable search” if the patient has not provided consent to the procedure); *State v. McKnight*, 576 S.E.2d 168, 178–79 (S.C. 2003) (holding that a urine sample taken from Regina McKnight while in the hospital, which was used in her conviction for homicide by child abuse, did not violate her Fourth Amendment rights). Fortunately for McKnight, her petition for post-conviction relief was granted and she was released from prison. *McKnight v. State*, 661 S.E.2d 354, 356 (S.C. 2008); Sharon Greene, *Regina McKnight Released from Prison*, CAROLINALIVE.COM (June 19, 2008, 6:23 PM), <http://www.carolinalive.com/news/story.aspx?id=149364#UswdqfRDu4I>.

82. Paltrow & Flavin, *supra* note 4, at 303.

83. See Brief of *Amici Curiae* American Civil Liberties Union, American Civil Liberties Union of Florida, and American Medical Women’s Association in Support of Appellant at 2, *Burton v. Florida*, 49 So.3d 263 (Fla. Dist. Ct. App. Aug. 12, 2010) (No. 1D09-1958), available at https://www.aclu.org/files/pdfs/reproductiverights/burton_v_florida_acluamicus.pdf [hereinafter ACLU Brief].

84. According to the Cleveland Clinic, nearly 20 percent of pregnant women are prescribed some form of bed rest each year. *Pregnancy Bed Rest*, CLEVELAND CLINIC, http://my.clevelandclinic.org/healthy_living/pregnancy/hic_pregnancy_bed_rest.aspx (last visited Apr. 9, 2014).

85. See James, *supra* note 54.

86. See Lisa Belkin, *Is Refusing Bed Rest a Crime?*, N.Y. TIMES (Jan. 12, 2010, 12:50 PM), <http://parenting.blogs.nytimes.com/2010/01/12/is-refusing-bed-rest-a-crime/> (“Burton asked to switch hospitals and the request was denied by the court.”). Burton’s attorney argued that there were a number

relegated to conditions emblematic of solitary confinement;⁸⁷ she remained alone in a dreary hospital room until her fetus died and was surgically removed three days later.⁸⁸

Forced medical solitary confinement, while distinct from prison solitary confinement, shares relevant parallels that trigger human and constitutional rights concerns pertaining to the deprivation of liberty, forced institutional restraint, isolation from the general population and community, the denial of contact, loss of freedom to move within a facility, mental health deterioration, and stigma. Individually and collectively, conditions such as these raise significant concerns related to human dignity, so much so that Senator Dick Durban cautioned that only when “absolutely necessary” should confinement be used in the prison context.⁸⁹ The same is true in medicine. Senator John McCain recounted from personal experience that “it’s an awful thing, solitary. It crushes your spirit and weakens your resistance more effectively than any other form of mistreatment.”⁹⁰ More than a century ago, the U.S. Supreme Court recounted the devastating effects of solitary confinement on prisoners:

A considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane, others still, committed suicide . . . and in most cases did not recover sufficient mental activity to be of any subsequent service to the community.⁹¹

In 2012, the Senate Judiciary Committee’s Subcommittee on the Constitution, Civil Rights and Human Rights took up these concerns in a hearing entitled “Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences.”⁹² Senator Patrick Leahy issued a statement

of more appropriate treatment options for Burton, including bed rest at home, that would have allowed her to take care of her two daughters. Martha Neil, *Pregnant Pro Se Mom Argued Treatment Case from Hospital Bed & Lost; Will Lawyer Win Appeal?*, ABA J. (Jan. 26, 2010, 3:22 PM), http://www.abajournal.com/news/article/observers_await_appellate_ruling_in_suit_over_court-ordered_treatment_of_pr/.

87. On petition by the State Attorney, the order was granted. *In re* Unborn Child of Samantha Burton, No. 2009 CA 1167, 2009 WL 8628562 (Fla. Cir. Ct. Mar. 27, 2009). The court order authorized the hospital to take action “necessary to preserve the life and health of Samantha Burton’s unborn child, including but not limited to restricting [her] to bed rest, administering appropriate medication, postponing labor, taking appropriate steps to prevent and/or treat infection, and/or eventually performing a cesarean section delivery of the child at the appropriate time.” *Id.*

88. Belkin, *supra* note 86.

89. *Reassessing Solitary Confinement: The Human Rights, Fiscal and Public Safety Consequences: Hearing Before the Subcomm. on the Const., Civ. Rts. & Hum. Rts. of the S. Comm. on the Judiciary*, 112th Cong. (2012) (statement of Sen. Dick Durbin) [hereinafter *Reassessing Solitary Confinement Hearing*], available at http://www.judiciary.senate.gov/imo/media/doc/12-6-19_DurbinStatement.pdf.

90. U.S. Senator John McCain, on his treatment as a prisoner of war. JOHN MCCAIN & MARK SALTER, *FAITH OF MY FATHERS* 206 (1999).

91. *In re* Medley, 134 U.S. 160, 168 (1890).

92. *Reassessing Solitary Confinement Hearing*, available at <http://www.judiciary.senate.gov/meetings/reassessing-solitary-confinement-ii-the-human-rights-fiscal-and-public-safety-consequences>.

acknowledging that “[a]lthough solitary confinement was developed as a method for handling highly dangerous prisoners, it is increasingly being used with inmates who do not pose a threat to staff or other inmates.”⁹³ Among those forced into confinement are many “who don’t really need to be there” from “vulnerable groups like immigrants, children, [and] LGBT inmates supposedly there for their own protection.”⁹⁴ Relevantly, confinement is not simply deleterious because of forced isolation; it often represents misuse of state-sanctioned authority by individuals in charge of vulnerable populations.⁹⁵

Hospitals, like prisons, “are psychologically powerful places, ones that are capable of shaping and transforming the thoughts and actions of the persons who enter them.”⁹⁶ Often, patients benefit from their hospital experiences, but sometimes medical stays are counterproductive and adverse, as in Samantha Burton’s experience. According to the circuit court judge, John Cooper, Burton’s physician deemed it “necessary to ‘preserve the life and health of Samantha Burton’s unborn child.’”⁹⁷ In deferring to perceived medical authority and accommodating Tallahassee Memorial Hospital (TMH) staff’s requests, the Leon County Circuit Court ordered Burton’s indefinite confinement.⁹⁸ The trial court issued a rule that stated “as between parent and child, the ultimate welfare of the child is the controlling factor,”⁹⁹ and found that Florida’s interests in the fetus “override Ms. Burton’s privacy interests at this time.”¹⁰⁰

Consequently, the court granted Burton’s physicians the authority to take whatever medical course of action necessary to achieve their goals—even against the patient’s will, including performing a nonconsensual cesarean delivery¹⁰¹—despite the fact that there was no case precedent in Florida state law that upheld forcing a pregnant woman to undergo confinement and medical treatment for the benefit of a fetus.¹⁰² The court issued the following relief for TMH:

Tallahassee Memorial HealthCare, Inc., Dr. Jana Bures-Forsthofel, members and employees of Dr. Forsthofel’s medical practice and other attending health care providers are hereby authorized to provide

93. *Reassessing Solitary Confinement Hearing* (statement of Sen. Patrick Leahy), available at http://www.judiciary.senate.gov/imo/media/doc/leahy_statement_06_19_12.pdf.

94. Durbin, *supra* note 89.

95. Leahy, *supra* note 93 (noting that, “far too often, prisoners today are placed in solitary confinement for minor violations that are disruptive but not violent.”).

96. *Reassessing Solitary Confinement Hearing* (statement of Prof. Craig Haney), available at <http://www.judiciary.senate.gov/imo/media/doc/12-6-19HaneyTestimony.pdf>.

97. ACLU Brief, *supra* note 83, at 2.

98. *In re Unborn Child of Samantha Burton*, No. 2009 CA 1167, 2009 WL 8628562 (Fla. Cir. Ct. Mar. 27, 2009).

99. *Burton v. State*, 49 So.3d 263, 265 (Fla. Dist. Ct. App. 2010).

100. *Id.*

101. *Id.*

102. *Id.*

such medical care and treatment to Samantha Burton and her unborn child as in their reasonable professional judgment is necessary to preserve the life and health of Samantha Burton's unborn child, including but not limited to restricting Samantha Burton to bed rest, administering appropriate medication, postponing labor, taking appropriate steps to prevent and/or treat infection, and/or eventually performing a cesarean section delivery of the child at the appropriate time. Samantha Burton is ordered to comply with the attending physician's orders with regard to such medical care and treatment.¹⁰³

The court also ordered TMH to notify the Florida Department of Children and Families, and other applicable agencies, to intervene as necessary in the monitoring of Samantha Burton's children,¹⁰⁴ a process that necessarily leads to a file alleging some form of parental absence, neglect, or abuse.¹⁰⁵

In this case, law and medicine intersected in pernicious ways, extending even beyond the physician's decision to seek an order to confine Burton against her will. For example, Burton was not provided any legal representation at the civil commitment hearing, despite the significant liberty interests at stake.¹⁰⁶

This well-established principle is no less salient in civil cases. For example, in *Lassiter v. Department of Social Services*, the Supreme Court ruled that the Due Process Clause of the Fourteenth Amendment establishes a right to counsel when the state risks depriving an individual of her physical liberty.¹⁰⁷ The Court stressed an interest-balancing test, weighing government interest against private interest, "and the risk that the procedures used will lead to erroneous decisions."¹⁰⁸ The Court established that there is a presumption to a right to appointed counsel in adjudications where the indigent, "if he is unsuccessful, may lose his personal freedom."¹⁰⁹ A decade earlier, *In re Gault* reached a similar conclusion, establishing a right to counsel for civil delinquency proceedings, "which may result in commitment to an institution in which the juvenile's freedom is curtailed."¹¹⁰

103. *In re Unborn Child of Samantha Burton*, No. 2009 WL 8628562.

104. *Id.*

105. As a "mandatory reporter" under Florida law, TMH must report "known or suspected child abuse, abandonment, or neglect by a parent" to allow the Florida Department of Children and Families to undertake "protective investigation." FLA. STAT. ANN. § 39.201(2)(a) (West 2013).

106. *Burton v. State*, 49 So.3d 263, 266–67 (Fla. Dist. Ct. App. 2010) (Van Nortwick, J., concurring). Over fifty years ago in its landmark ruling, *Gideon v. Wainwright* (a case that originated in Florida courts), the U.S. Supreme Court affirmed that the Sixth Amendment establishes a constitutional right to appointed counsel in criminal cases. In that case, the Court found "[f]rom the very beginning, our state and national constitutions and laws have laid great emphasis on procedural and substantive safeguards designed to assure fair trials before impartial tribunals in which every defendant stands equal before the law. This noble ideal cannot be realized if the poor man charged with crime has to face his accusers without a lawyer to assist him." *Gideon v. Wainwright*, 372 U.S. 335 (1963).

107. *Lassiter v. Dep't of Soc. Servs.*, 452 U.S. 18, 26–27 (1981).

108. *Id.* at 27.

109. *Id.*

110. *In re Gault*, 387 U.S. 1, 36 (1967).

As acknowledged on appeal, Burton's physical and liberty interests were no less paramount than the interests at stake in *Lassiter* and *In re Gault*. She was involuntarily hospitalized and mandated to undergo an invasive medical procedure that required anesthesia and the insertion of a broad incision in the abdomen and a second in the uterus. These procedures are painful post-operatively and can render the patient vulnerable to infection at the point of incision in the abdomen or uterus, blood clots in the legs or lungs, heavy blood loss, and drug side effects such as migraines, nausea, and vomiting.¹¹¹ Cesarean surgeries can leave weak spots in the uterus, making subsequent efforts for a vaginal delivery risky.¹¹² Yet, no counsel appeared to address these concerns (and others) until after the forced cesarean section had occurred.¹¹³ As Judge William Van Nortwick admonished in a concurring opinion, appointment of counsel subsequent to the hearing and after such a significant invasion of privacy cannot satisfy the clear due process requirement established by the Constitution.¹¹⁴

Beyond concerns relating to the right to counsel, physical deprivations of liberty, and privacy—including Burton's confinement violating her fundamental privacy right as enumerated in Florida's constitution, "to be let alone and free from government intrusion into the person's private life"¹¹⁵—this case is troubling for other reasons overlooked by the District Court of Appeal.

Burton's experience is an alarming illustration of the unconstitutional constraints imposed on pregnant women's right to security in their bodies. Were it not for a pattern of "legislative and judicial misrepresentation and misuse of medical information"¹¹⁶ in the politicized agenda to dismantle reproductive rights, this case could be read as a particularly chilling, but isolated, example of an unconstitutional breach of privacy. But context prevents that narrow view of this case. Thus, the court could have found that the seizure

111. AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, FAQ: CESAREAN BIRTH (2011), available at <http://www.acog.org/~media/For%20Patients/faq006.pdf?dmc=1&ts=20140107T1622543905>; Mayo Clinic Staff, *C-Section: Risks*, MAYO CLINIC (last visited Apr. 9, 2013), <http://www.mayoclinic.org/tests-procedures/c-section/basics/risks/PRC-20014571>.

112. AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, FAQ: VAGINAL BIRTH AFTER CESAREAN DELIVERY: DECIDING ON A TRIAL OF LABOR AFTER CESAREAN DELIVERY (2011), available at <http://www.acog.org/~media/For%20Patients/faq070.pdf?dmc=1&ts=20140107T1629078036> (discussing the risk that the cesarean scar on the uterus or the uterus itself can rupture in subsequent vaginal births).

113. *Burton v. State*, 49 So.3d 263, 267 (Fla. Dist. Ct. App. 2010) (Van Nortwick, J., concurring) (noting that "no counsel appeared on [Ms. Burton's] behalf until after the caesarian section was performed.").

114. *Id.*

115. *Id.* at 265 (quoting FLA. CONST. art. I, § 23).

116. R. Alta Charo, *Physicians and the (Woman's) Body Politic*, NEW ENG. J. MED. (2014), available at <http://www.nejm.org/doi/pdf/10.1056/NEJMp1313499>.

of Burton's body violated both the Fourth¹¹⁷ and Fourteenth Amendments (unlawful seizure by government officials and deprivation of liberty without due process, respectively). The subsequent seizure of her fetus may also have violated the Fourteenth Amendment's liberty guarantee articulated in *Newman*¹¹⁸ because the effect of TMH's actions amounted to the unconstitutional search and seizure of Burton's body as well as the fetus she gestated.¹¹⁹ In medical cases involving the nonconsensual harvesting of corneas from cadavers, the Ninth and Sixth Circuits have found such actions to be unconstitutional and in violation of litigants' Fourteenth Amendment due process interests.¹²⁰ A pregnant woman's interest in her fetus can be no less salient than a spouse's interest in her deceased husband's corneas.

Nevertheless, Burton's doctor and other hospital medical staff interpreted state law to provide that fetal protection interests trumped the liberty and privacy interests of their pregnant patient. Burton's case thus poses a serious question: Are health care providers in the best position to make legal

117. The Fourth Amendment would apply even though *Burton* is a civil proceeding, because as the Supreme Court has explained, "[T]he Fourth Amendment [is] applicable to the activities of civil as well as criminal authorities . . ." *New Jersey v. T.L.O.*, 469 U.S. 325, 335 (1984). And even if health care providers' motives for the seizure were benign or for Burton or her fetus's "benefit," the Supreme Court has also held that such a motive "cannot justify a departure from Fourth Amendment protections." *Ferguson v. Charleston*, 532 U.S. 67, 85 (2001).

118. See *Newman v. Sathyavaglswaran*, 287 F.3d 786, 789 (9th Cir. 2002) (noting that "the Supreme Court has repeatedly affirmed the right of every individual to the possession and control of his own person, free from all restraint or interference of others is so rooted in the traditions and conscience of our people, as to be ranked as one of the fundamental liberties protected by the substantive component of the Due Process Clause."); *Brotherton v. Cleveland*, 923 F.2d 477, 482 (6th Cir. 1991) (discussing an individual's "possessory right to his body" and a wife's "legitimate claim of entitlement" to her deceased husband's body, which are protected by the Fourteenth Amendment). In *Ferguson*, the U.S. Supreme Court found that the Medical University of South Carolina breached the petitioners' constitutional interests to be free from unlawful searches and seizures, ruling that the nonconsensual use of the mothers' urine tests to obtain evidence of drug use constituted unlawful searches in violation of their constitutional rights. 532 U.S. at 85–86.

119. The Fourth Amendment would apply even though *Burton* is a civil proceeding, because as the Supreme Court has explained, "the Fourth Amendment [is] applicable to the activities of civil as well as criminal authorities . . ." *T.L.O.*, 469 U.S. at 335.

120. *Brotherton*, 923 F.2d at 482. Two decades ago, the Sixth Circuit ruled that Deborah Brotherton's constitutionally protected property interest in her deceased husband's corneas had been violated by the local coroner when the coroner authorized a nonconsensual eye-tissue removal from Mr. Brotherton. *Id.* In Ohio and all other states, the immediate next of kin (the spouse, if married) is granted the authority to gift or decline tissues and organs donation in such situations. *Id.* In this case, Mrs. Brotherton refused to make such a donation and she objected to the procedure in writing. *Id.* Despite Mrs. Brotherton's explicit objections to that procedure, which were noted in Mr. Brotherton's medical record, the coroner proceeded with the extraction. *Id.* The Sixth Circuit held that Ms. Brotherton possessed a constitutionally protected property interest in her husband's corneas and that deprivation without a hearing violated her Fourteenth Amendment Due Process Clause interests. The court reasoned that Brotherton had an express interest in controlling the disposition of her husband's body. *Id.* at 482. A similar decision was reached by the Ninth Circuit in *Newman v. Sathyavaglswaran*, 287 F.3d at 799–800 (holding that the parents of deceased children had an interest in the disposition of their deceased children's bodies that must be weighed against the state's interest in obtaining organs or other organs from deceased individuals).

determinations that may contravene fundamental interests and involve unlawful searches and seizures? And, while prosecutors and even courts may be perceived as appropriate checks on medical staff interpreting state laws to protect fetuses, their judgment is immune neither to the influence of moral panic nor to doctors' assertions of medical urgency, particularly given the common but erroneous perception that medicine and science are infallible.¹²¹ Indeed, the judge who granted the confinement order denied Burton's request to switch hospitals because "such a change is not in the child's best interest at this time," a chilling reference given Burton's liberty interests at that stage and that the fetus was not yet born.¹²²

What is also alarming about this example is that although Burton's case ultimately came to light through the American Civil Liberties Union's (ACLU) advocacy on her behalf, it did so only after three days of involuntary confinement and a forced cesarean section.¹²³ While the confinement order was overturned on appeal,¹²⁴ this provided only a symbolic victory on the constitutional merits of Burton's claims that her autonomy and bodily integrity were unconstitutionally violated by the state.

The problem inherent in medical experiences like Burton's is that complications during pregnancy are not unique. Burton's symbolic victory does not change the fact that as long as fetal protection laws exist, medical personnel may be perversely incentivized to mistreat other women similarly situated to

121. The "crack baby myth" is a prime example of the fact that medicine and science are *not* infallible. See Michael Winerip, *Revisiting the 'Crack Babies' Epidemic that was Not*, N.Y. TIMES, May 20, 2013 [hereinafter *Revisiting the 'Crack Babies' Epidemic*], http://www.nytimes.com/2013/05/20/booming/revisiting-the-crack-babies-epidemic-that-was-not.html?_r=0. This myth was perpetuated by limited scientific studies in the 1980s that predicted "a generation of children would be damaged for life." *Id.* These predictions, touted by the media and politicians seeking to "crack down" on drug users, were wrong and blown out of proportion. *Id.* See also Deborah A. Frank et al., *Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure*, 285 JAMA 1613, 1613, 1622–24 (2001) (finding "no convincing evidence that prenatal cocaine exposure is associated with developmental toxic effects that differ in severity, scope, or kind from the sequel of multiple other risk factors," such as alcohol or the quality of the child's environment); Hallam Hurt et al., *Children with In Utero Cocaine Exposure Do Not Differ From Control Subjects on Intelligence Testing*, 151 ARCHIVES OF PEDIATRIC & ADOLESCENT MED. 1237, 1241 (1997) [hereinafter *Children with In Utero Cocaine Exposure Do Not Differ from Control Subjects on Intelligence Testing*] (finding no difference between the intelligence test results of cocaine-exposed children and a control group at four years of age); Hallam Hurt et al., *School Performance of Children with Gestational Cocaine Exposure*, 27 NEUROTOXICOLOGY & TERATOLOGY 203, 207 (2011) (finding no statistically significant difference between successful grade progression in grades 1–4 between children with gestational cocaine exposure and a control group) [hereinafter *School Performance of Children with Gestational Cocaine Exposure*]. In Regina McKnight's final adjudication, in which the Supreme Court of South Carolina reversed McKnight's conviction of homicide by child abuse, the court explicitly pointed out the expert witnesses' problematic use of "apparently outdated scientific studies," which the jury likely used in its conclusion that McKnight was guilty. *McKnight v. State*, 661 S.E.2d 354, 360–61, 366 (S.C. 2008).

122. Belkin, *supra* note 86.

123. See James, *supra* note 54.

124. See *Burton v. Florida*, 49 So.3d 263, 266 (Fla. Dist. Ct. App. 2010).

Burton. The appellate decision suggests that even with this vindication and clear rule of law, women might only be compensated retroactively for the violation of their fundamental rights, which is alarmingly inadequate. Indeed, the court reviewing Burton's confinement held that the case was reviewable, even though Burton's pregnancy and confinement had both ended, because the issue posed by the case would otherwise be "capable of repetition yet evading review."¹²⁵ Since many women will become pregnant and undoubtedly many of those will experience sickness, anxiety, depression, or risk during their gestations, many more similarly situated pregnant women could experience similar liberty deprivations if obstetricians continue to prioritize law enforcement objectives over women's fundamental interests. As a policy matter, we should be concerned that fetal protection laws encourage doctors to subordinate pregnant women's interests to the supposed interests of their fetuses in a way that violates these women's fundamental rights.

2. *Christine Taylor's Arrest for Tripping While Pregnant*

Fetal protection cases like Burton's illuminate the great heights medical staff and prosecutors will scale in the name of protecting fetal interests. As the Christine Taylor case illustrates, the subordination of women's rights, reduction of their expectations of privacy, and scaling back of important constitutional protections appear concomitant with furthering those interests, particularly when FPLs authorize criminal prosecution. The two cases reveal an absurdity in the range of conduct possible to trigger significant constitutional deprivations of liberty and privacy. Like Samantha Burton, Christine Taylor, a twenty-two-year-old pregnant mother of two living in Iowa, did not anticipate that a medical visit could result in her incarceration.

Taylor's "crime" was to trip and fall down the stairs during the second trimester of her pregnancy.¹²⁶ After receiving treatment from emergency medical technicians, she voluntarily sought further care at a hospital. During interviews with a nurse and a doctor, Taylor, a Maryland native, confided that she felt ambivalence about her pregnancy during its early stages. She shared intimate details about her estranged husband's threat that he was leaving her; he had already moved back to Maryland. Taylor explained her anxiety to an Iowa reporter: "And here I was alone, pregnant with two young kids, with no family around or support. I just thought, 'It's not fair.' . . . I was so upset and frantic I almost blacked out, and I tripped and fell."¹²⁷ She informed medical staff that because of this and the prospect of raising three children as a single parent, she

125. *Id.* at 264.

126. See Bryan Nichols, *Burlington Woman Will Not Be Charged with Feticide*, RADIO IOWA (Feb. 10, 2010), <http://www.radioiowa.com/2010/02/10/burlington-woman-will-not-be-charged-with-feticide/>.

127. Lee Rood, "I Never Said I Didn't Want My Baby": Mom Won't Be Prosecuted, DES MOINES REGISTER, Feb. 10, 2010, at 1A, 8A.

had considered both adoption and abortion after learning about the pregnancy. Thereafter, medical staff alerted the police, because they interpreted Taylor's case to fit within Iowa's criminal feticide statute, which prohibits "intentionally terminat[ing] a human pregnancy after the end of the second trimester of the pregnancy"¹²⁸

It is difficult to know what exactly triggered the medical staff's call to the police, other than the fact they believed Taylor had attempted to kill her fetus. Was it a misperception that even considering an abortion during the first trimester of a pregnancy served as sufficient evidence that a harmless fall months later violated the state's feticide law? According to a reporter who interviewed Taylor, "she believes the personal views of medical workers . . . played a part in a decision to accuse her last month of attempted feticide."¹²⁹ Could it have been that Taylor simply lacked credibility to medical staff who assumed that, given her earlier ambivalence about the pregnancy, the fall was a surreptitious attempt to abort her fetus? Or might this case simply be about a perceived medical duty to report? In other words, given the pressure and anxiety experienced by medical personnel to serve not only as interpreters of state fetal protection laws, but also as informants on their patients, perhaps the medical staff believed that the Iowa law required physicians to report any and all medical visits indicating an intentional or negligent threat of harm to a fetus. It may be that the medical staff believed they were simply doing what was legally expected of them and failure to report would risk their license. Even so, under any of these circumstances, the call to police and Taylor's subsequent ordeal serve as chilling examples about the misuse and misapplication of fetal protection laws.

Taylor's pregnancy survived her fall,¹³⁰ nevertheless, she was arrested shortly after leaving the hospital and returning home to her children. Two squad cars intercepted her taxi and officers arrested her. Christine Taylor was incarcerated at the local jail for two days, while police launched an investigation to determine whether she meant to kill her fetus by tripping in her home.¹³¹ For three weeks, local prosecutors pursued their attempted feticide investigation against her until the case was dropped. But, according to the prosecutor, this was only because Taylor was not yet in the third trimester of her pregnancy when she fell, which brought her outside of the feticide statute.¹³²

In both fetal protection cases described in this Section, physicians erred in their interpretation of law; there was no legal foundation for the forced confinement and cesarean section ordered in Burton's case, and Taylor's doctor

128. IOWA CODE ANN. § 707.7 (West 2011).

129. Rood, *supra* note 127.

130. Nichols, *supra* note 126.

131. Rood, *supra* note 127.

132. *Id.*

lacked sufficient legal grounds to alert law enforcement.¹³³ Tripping down steps while pregnant may cause injury to a woman and her fetus but it is not a crime, even if the nurse and doctor treating her disbelieved Taylor's version of events. Importantly, the medical staff misread Iowa's feticide law, the statute in question.

3. Rennie Gibbs's Charge of Depraved Heart Murder in Stillbirth Case

Rennie Gibbs's ongoing criminal prosecution in Mississippi for depraved heart murder of her dead fetus¹³⁴ further illustrates the extent to which physicians and medical staff may misconstrue and misinterpret fetal protection laws, while in the process trampling pregnant patients' constitutional rights and triggering criminal prosecutions. As with Taylor's encounter at a hospital in Iowa, which resulted in her arrest, the prosecution of Gibbs, an African American teen, hinged on a doctor's construal of her conduct toward her stillborn infant.¹³⁵ In Gibbs's case, the medical examiner claimed Gibbs's drug addiction, which did not abate during pregnancy, demonstrated indifference toward the life of her fetus, and its death was the direct result of her depraved heart. Her arrest and prosecution following a traumatic perinatal outcome is yet another example of the misuse and misapplication of medical information for politicized reproductive purposes. Unlike Taylor's traumatic ordeal, Gibbs's prosecution, which began in 2006, continued until early April 2014 when a judge dismissed the case. Mississippi prosecutors threaten to retry the case. If convicted of depraved heart murder for birthing a stillborn baby, Rennie Gibbs will face a mandatory life sentence.¹³⁶

Gibbs was only fifteen years old when she became pregnant, and although a teenager, she struggled with drug dependence on crystallized cocaine.¹³⁷ In

133. Notably, in both cases, subsequent legal actors (a judge in one and police officers in the other) relied on the statements of physicians in determining that confinement was the next appropriate course of action.

134. See Calhoun, *supra* note 80; Associated Press, *Court to Hear Case of Woman Accused in Stillbirth*, JACKSON FREE PRESS (Apr. 1, 2013 10:39 AM), <http://www.jacksonfreepress.com/news/2013/apr/01/court-hear-case-woman-accused-stillbirth/> (discussing two pending cases in Mississippi prosecuting Rennie Gibbs and Nina Buckwalter for stillborns' deaths).

135. Associated Press, *Court to Hear Case of Woman Accused in Stillbirth*, *supra* note 134; Calhoun, *supra* note 80.

136. Brief of Appellant at 36, *Gibbs v. State*, (Miss. Nov. 12, 2010) (No. 2010-M-819) [hereinafter Brief of Appellant, *Gibbs v. State*], available at <http://judicial.mc.edu/briefs/2010-IA-00819-SCTT.pdf> ("Under the statutory interpretation advanced by the prosecution, Ms. Gibbs faces life in prison because of her combined status as a pregnant woman and drug user."). The statute at issue reads: "The killing of a human being with the authority of law by any means or in any manner shall be murder in the following cases: . . . (b)When done in the commission of an act eminently dangerous to others and evincing a depraved heart, regardless of human life, although without premeditated design to effect the death of any particularly individual, shall be second-degree murder." MISS. CODE ANN. § 97-3-19(B) (West 2013). MISS. CODE ANN. § 97-3-21(2) (West 2013) provides that "a person who shall be convicted of second-degree murder shall be imprisoned for life . . . if the punishment is so fixed by the jury."

137. Brief of Appellant, *Gibbs v. State*, *supra* note 136, at 1.

December of 2006, one month after turning sixteen, Gibbs suffered a stillbirth¹³⁸ in the thirty-sixth week of her pregnancy.¹³⁹ Dr. Steven Hayne performed an autopsy on the dead baby and concluded that it suffered from in utero exposure to cocaine, which caused its death.¹⁴⁰ He ruled the stillbirth a murder, which is consistent with a long-standing, misinformed politicization of science dating back to the 1980s that misrepresents the risks of in utero cocaine exposure.¹⁴¹ That is, crack use became a particularly targeted offense during the U.S. War on Drugs, earning its convicted users grossly disparate, tougher sentences than that of powder cocaine sellers and users. The sentencing disparity, only recently addressed in 2013 by U.S. Attorney General Eric Holder,¹⁴² was 100 to 1, because politicians speciously claimed crack caused more socially deleterious behavior than powder cocaine, such as violence, crime, and the birth of “crack babies” (supposed biologically inferior children permanently hampered by physical and cognitive disabilities).¹⁴³

As a result, pregnant addicts endured a particularly unique attack not only as intensified targets of the drug war, but also as “bad mothers” on the path toward swamping the United States with crack babies, who develop into uneducable, disabled, and malformed children.¹⁴⁴ States responded by prosecuting women under existing child abuse statutes for drug dependence occurring during pregnancy. However, meticulous empirical studies debunking politicized and inaccurate science on crack were published in leading peer-reviewed journals years before Gibbs’s arrest and in the years since this prosecution began.¹⁴⁵ For example, on the basis of thirty-six studies, Deborah

138. *Id.*

139. Brief of Amicus Curiae of the Nat’l Ass’n of Soc. Workers et al. in support of Petitioner Rennie T. Gibbs at 1–2, *Gibbs v. State*, (Miss. May 19, 2010) (No. 2010-M-819) [hereinafter NASW Amicus Brief], available at <http://www.socialworkers.org/assets/secured/documents/ldf/brief%20Documents/Gibbs%20v%20State%20MS%20Sup.Ct.Amicus%20Brief.pdf>.

140. Brief of Appellant, *Gibbs v. State*, *supra* note 136, at 1.

141. This Article does not advocate drug use of any kind during pregnancy. Instead, it distinguishes the misinformed and misused scientific conjecturing rooted in the 1980s’ politicization of drug addiction (that spawned the U.S. War on Drugs as well as the crack baby mythology) from rigorous scientific research that provides a credible account of fetal exposure to cocaine and other drugs.

142. Eric Holder, Att’y Gen., Remarks at the Annual Meeting of the American Bar Association’s House of Delegates (Aug. 12, 2013), available at <http://www.justice.gov/iso/opa/ag/speeches/2013/ag-speech-130812.html>.

143. Charles Krauthammer, *Worse Than ‘Brave New World’: Newborns Permanently Damaged by Cocaine*, PHILA. INQUIRER, Aug. 1, 1989, http://articles.philly.com/1989-08-01/news/26148256_1_cocaine-babies-crack-babies-damage.

144. *Id.* (“The inner-city crack epidemic is now giving birth to the newest horror: a bio-underclass, a generation of physically damaged cocaine babies whose biological inferiority is stamped at birth.”).

145. Frank et al., *supra* note 121. Dr. Hallam Hurt, former Chairwoman of the Division of Neonatology at the Albert Einstein Medical Center, conducted the longest research study on fetal cocaine exposure. In a 2009 study, she reported:

[I]n middle school-aged children, we found no evidence of impaired [neurocognitive] function caused by gestational cocaine exposure, despite the fact that our sample size was

Frank and her co-investigators reported in the *Journal of the American Medical Association* in 2001 that “there is no convincing evidence that prenatal cocaine exposure is associated with developmental toxicity effects different in severity, scope or kind from the sequelae of multiple other risk factors.”¹⁴⁶ Hallam Hurt’s 1997 study reported that children with in utero cocaine exposure did not differ from control subjects on intelligence testing.¹⁴⁷ Both Hurt and Frank attribute poverty and co-founding factors to poor outcomes in children exposed to cocaine.

Nevertheless, stereotypes about crack babies persist, as does Gibbs’s prosecution, despite rigorous scientific evidence discrediting unreliable medical and political accounts about fetal cocaine exposure. Based on Dr. Hayne’s autopsy report, which ruled Gibb’s stillbirth a murder, Gibbs was arrested on February 4, 2007, charged with depraved heart murder for “kill[ing] her unborn child, a human being, while engaged in the commission of an act eminently dangerous to others and evincing a depraved heart, by using cocaine while pregnant with her unborn child . . . in violation of MCA § 97-3-19.”¹⁴⁸ And, although she was barely sixteen at the time, Rennie Gibbs was charged as an adult.

This case rests significantly on the testimony and medical examination report issued by Dr. Haynes. That Gibbs’s fetus expired in stillbirth is undisputed. However, the factors that ultimately contributed to its death are not indisputable as prosecutors suggest, because “stillbirth is one of the most common adverse outcomes of pregnancy,”¹⁴⁹ and it results from any number of

adequate to detect a statistically and clinically significant difference (effect size of 0.5) and we used a [neurocognitive] battery shown to be sensitive to age and IQ. . . . We found no difference between groups even with isolation of specific cognitive systems for evaluation of cocaine effects.

Hallam Hurt et al., *Children With and Without Gestational Cocaine Exposure: A Neurocognitive System Analysis*, 31 NEUROTOXICOLOGY & TERATOLOGY 334, 339 (2009). See also Susan FitzGerald, “Crack Baby” Study Ends With Unexpected But Clear Result, PHILA. INQUIRER, July 22, 2013, http://articles.philly.com/2013-07-22/news/40709969_1_hallam-hurt-so-called-crack-babies-funded-study; Hallam Hurt et al., *A Prospective Comparison of Developmental Outcome of Children with In Utero Cocaine Exposure and Controls Using the Battelle Developmental Inventory*, 22 J. DEV. & BEHAV. PEDIATRICS 21 (2001); Hurt et al., *Children With In Utero Cocaine Exposure Do Not Differ From Control Subjects on Intelligence Testing*, supra note 121; Hurt et al., *School Performance of Children With Gestational Cocaine Exposure*, supra note 121, at 203 (concluding that “[i]n this inner-city cohort, cocaine-exposed and control children had similar poor school performance. Better home environment and higher Intelligence Quotient conferred an advantage for successful grade progression, regardless of gestational cocaine exposure.”); Janine Jackson, *The Myth of the “Crack Baby”: Despite Research, Media Won’t Give Up Idea of “Bio-Underclass,”* EXTRA!, Sept. 1, 1998, <http://fair.org/extra-online-articles/the-myth-of-the-crack-baby/>.

146. Frank et al., supra note 121, at 1622–24.

147. Hallam Hurt et al., *Children with In Utero Cocaine Exposure Do Not Differ from Control Subjects on Intelligence Testing*, supra note 121.

148. Brief of Appellant, *Gibbs v. State*, supra note 136.

149. R.L. Goldenberg et al., *Stillbirth: A Review*, 16 J. MATERNAL-FETAL & NEONATAL MED. 79, 79 (2004).

factors.¹⁵⁰ Upwards of 30 percent of pregnancies will terminate in miscarriage or stillbirth.¹⁵¹ Notwithstanding rigorous efforts to identify what causes perinatal fetal mortality, researchers report that “a substantial portion of fetal deaths are still classified as unexplained intrauterine fetal demise”¹⁵² because stillbirths are linked to environment,¹⁵³ poverty,¹⁵⁴ stress,¹⁵⁵ diabetes,¹⁵⁶ hypertension,¹⁵⁷ and sexually transmitted diseases.¹⁵⁸ The American Congress of Obstetricians and Gynecologists (ACOG) attributes stillbirths to race, as Black women are nearly twice as likely to suffer a stillbirth as compared to all other women.¹⁵⁹ For example, Black women’s stillbirth rate occurs at 11.25 per 1,000 births compared to Asian, white, and Native American women, all of whom experience stillbirth at rates less than 6 per 1,000.¹⁶⁰ This disparity persists even among Black women who receive “adequate” prenatal care.¹⁶¹

Gibbs’s prosecution is one of first impression in Mississippi, as no woman or girl has been charged with such a crime for birthing a stillborn. According to

150. Robert M. Silver et al., *Work-up of Stillbirth: A Review of the Evidence*, 196 AM. J. OBSTETRICS & GYNECOLOGY 433, 440 (2007) (noting that multiple factors may contribute to a stillbirth, but not cause it).

151. Brief of Appellant, *Gibbs v. State*, *supra* note 136, at 30; Brief of Amicus Brief NASW, *supra* note 139, at 4; Claudia Malacrida, *Complicated Mourning: The Social Economy of Perinatal Death*, 9 QUALITATIVE HEALTH RES. 504, 505 (1999).

152. Melissa A. Sims & Kim A. Collins, *Fetal Death: A 10-Year Retrospective Study*, 22 AM. J. FORENSIC MED. & PATHOLOGY 261, 261 (2001).

153. “Environment” could include both the physical, natural environment (such as exposure to toxins) as well as social environment (income, education, etc.). *See, e.g.*, Carol J. Rowland Hogue, *Demographics & Exposures*, in *STILLBIRTH: PREDICTION, PREVENTION AND MANAGEMENT* 57, 69–70 (Catherine Y. Spong ed. 2011) (discussing various social environment factors’ impact on stillbirth risk); Marc Edwards, *Fetal Death and Reduced Birth Rates Associated with Exposure to Lead-Contaminated Drinking Water*, 48 ENVIRON. SCI. & TECH. 730 (2014).

154. Victoria Flenady et al., *Major Risk Factors for Stillbirth in High-Income Countries: A Systemic Review and Meta-Analysis*, 337 LANCET 1331, 1337 (2011) (noting that “women from disadvantaged populations in high-income countries continue to have stillbirth rates far in excess of those living without such disadvantage. . . . [P]overty could be the overriding factor preventing access to care” and thereby increasing risk of stillbirth).

155. Hogue, *supra* note 153, at 71 (discussing a growing body of evidence that stress may affect stillbirth risk). *See also* K. Wisborg et al., *Psychological Stress During Pregnancy and Stillbirth: Prospective Study*, 115 BJOG 882 (2008) (finding an association between psychological stress during pregnancy and an increased risk of stillbirth).

156. The Stillbirth Collaborative Research Network Writing Group, *Association Between Stillbirth and Risk Factors Known at Pregnancy Confirmation*, 306 JAMA 2470, 2471 (2011).

157. John C. Smulian et al., *Fetal Deaths in the United States: Influence of High-Risk Conditions and Implications for Management*, 100 OBSTETRICS & GYNECOLOGY 1183, 1183 (2002).

158. Goldenberg et al., *supra* note 149, at 85 (“[I]n areas where syphilis is prevalent, up to half of all stillbirths may be caused by this infection alone.”).

159. According to the American Congress of Obstetricians and Gynecologists, “the most prevalent risk factors associated with stillbirth are non-Hispanic black race, nulliparity [no previous births], advanced maternal age, and obesity.” ACOG Committee on Practice Bulletins—Obstetrics, *Management of Stillbirth*, 113 OBSTETRICS & GYNECOLOGY 748, 749 (2009).

160. ACOG Committee on Practice Bulletins—Obstetrics, *supra* note 159, at 749.

161. Stress, hypertension, and other medical, psychological, social, and economic factors uniquely prevailing on the lives of pregnant Black women may explain the gross disparity in stillbirths occurring in African American pregnancies. *Id.*

Gibbs's legal counsel, "there ha[ve] been no reported cases and no media reports showing that the State of Mississippi ha[s] ever applied the depraved-heart homicide statute to a pregnant woman who suffered a stillbirth or miscarriage."¹⁶² That no prior cases are reported of a pregnant woman charged with this offense is unsurprising, because the explicit language of the statute does not "encompass the death of an unborn child."¹⁶³ Nor does the legislation on its face include pregnant women within the scope of the class of persons who can be prosecuted for violating this statute.¹⁶⁴

For these reasons, Gibbs's attorneys continue to argue that the Mississippi legislature never intended the statute to apply to the unborn. They specifically cite the statutory language, highlighting that the statute underpinning Rennie Gibbs's prosecution, Mississippi Code § 97-3-37, "specifically provides that an 'unborn child' can be the victim of assault, capital murder, and certain types of manslaughter, but not depraved heart murder."¹⁶⁵ Moreover, they assert that because there is "no reference to 'unborn child[ren] in the depraved heart section of that statute, 97-3-19(1)(b)," the legislature never intended the law to apply against pregnant women and therefore the statute is misapplied against Miss Gibbs.¹⁶⁶ Despite a rigorous defense, on April 23, 2010, the Circuit Court of Lowndes County denied Gibbs's Motion to Dismiss.¹⁶⁷

B. Medical Staff Are Poor Interpreters of Law, and This New Focus on Law Compromises Their Medical Judgment

Importantly, both the Taylor and Burton cases demonstrate legislatures' reliance on medical staff to police risky pregnancy cases. Nurses and doctors serve as more than just the eyes and ears of the state. Instead, as a formal matter, these cases illustrate that medical staff are the primary detectives and enforcers of state fetal protection statutes, often with the support of police, prosecutors, and even judges. We should be concerned about non-legally-trained medical staff increasingly enforcing fetal protection laws, as thirty-eight states have adopted some form of feticide legislation.¹⁶⁸

162. Brief of Appellant, *Gibbs v. State*, *supra* note 136, at 2.

163. *Id.*

164. *Id.*

165. *Id.* at 1.

166. *Id.* at 2.

167. Subsequently, the Mississippi Supreme Court granted Gibbs's petition for interlocutory review. *Id.* at 2. Under Mississippi's Rules of Appellate Procedure, an interlocutory appeal [M]ay be sought if a substantial basis exists for a difference of opinion on a question of law as to which appellate resolution may:

(1) Materially advance the termination of the litigation and avoid exceptional expense to the parties; or

(2) Protect a party from substantial and irreparable injury; or

(3) Resolve an issue of general importance in the administration of justice.

MISS. R. APP. PROC. 5(a) (2008).

168. *Fetal Homicide Laws*, NAT'L CONF. STATE LEGS., <http://www.ncsl.org/research/health/fetal-homicide-state-laws.aspx> (last visited Apr. 9, 2014).

As these cases demonstrate, in applying fetal protection laws, medical staff may subordinate medical judgment and diagnosis objectives to their criminal law enforcement responsibilities, which itself introduces problematic norms into the physician-patient relationship. Specifically, medical staff may prioritize criminal punishment over fiduciary responsibilities to patients,¹⁶⁹ thus “requiring physicians to use less than the best medical judgment” in treating pregnant patients.¹⁷⁰ In some instances, pregnant women’s medical treatment is not merely subordinate but regarded as extraneous and peripheral. A South Carolina task force established at the Medical University of South Carolina (MUSC) and initiated by medical staff made clear that its role was to turn over noncompliant pregnant drug users to law enforcement officials.¹⁷¹ MUSC officials profiled their patients, singling out pregnant Black women to test for illicit drug use, relying on stereotypes and cultural biases to fulfill their law enforcement objectives.¹⁷²

Again, the problem is that medical staff are not only poor interpreters of law, but also, when they accept these legal roles, they do so at the expense of abrogating their medical duties. Doctors and nurses well know that there are medical reasons why pregnant women might not wish to undergo certain procedures.¹⁷³ Nevertheless, these reasons are downplayed in fetal protection cases, such that perverse medical consequences may result from the very medical procedures imposed to save fetuses¹⁷⁴ or mothers.

169. According to Solicitor Condon, a primary purpose of the task force established to address the issue of drug use during pregnancy was “to consider possible prosecution of the mothers of drug affected babies.” Reply Brief of Appellant-Petitioner at 9, *Ferguson v. Charleston*, 532 U.S. 67 (2001) (No. 99-936).

170. Charo, *supra* note 116.

171. Reply Brief of Appellant-Petitioner, *supra* note 169, at 9.

172. See *Ferguson v. Charleston*, 532 U.S. 67, 70–73 (2001) (describing the Medical University of South Carolina’s drug-screening program for pregnant woman suspected of using cocaine, but not of other substances); Roberts, *supra* note 5, at 1471 (“The singling out of Black mothers for punishment combines in a single government action several wrongs prohibited by” the Equal Protection Clause and the right of privacy and perpetuates “the legacy of racial discrimination embodied in the devaluation of Black motherhood.”).

173. For example, C-sections come with many risks to both mother and baby, such as increased risk of respiratory problems, longer recovery and hospital stays, maternal mortality, risk of the C-section scar tearing in future pregnancies and/or deliveries and these many risks are a reason women may prefer natural childbirth. See AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *CESAREAN BIRTH* (2011), <http://www.acog.org/~media/For%20Patients/faq006.pdf?dmc=1&ts=20121019T1416309306> (listing some of the complications of a C-section, including blood loss, blood clots, injury to bowel or bladder, and infection); ACOG Committee on Obstetric Practice, *Committee Opinion: Cesarean Delivery on Maternal Request*, 121 *OBSTETRICS & GYNECOLOGY* 904, 906 (2013) (recommending vaginal delivery in absence of maternal or fetal indication for cesarean delivery given the balance of risks and benefits between C-sections and vaginal deliveries); Danielle Buffardi, *Benefits of a Vaginal Birth*, AM. PREGNANCY ASS’N PREGNANCY BLOG (Feb. 3, 2012), <http://www.americanpregnancy.org/pregnancyblog/2012/02/benefits-of-a-vaginal-birth/>.

174. Bei Bei Shua’s prosecution involves a question of medical evidence. Prosecutors claim that the rat poison Shuai consumed caused the medical condition that resulted in the baby’s death. However, doctors presented compelling evidence that the treatments provided to save the baby’s life could have caused the condition from which the daughter died. See Charles Wilson, *Ind. Mom’s Lawyer: Cause of Baby’s Death Unproven*, ABC NEWS (Oct. 10, 2012, 4:55 PM), <http://bigstory.ap.org/article/ind-moms-lawyer-cause-babys-death-unproven>.

1. Marlise Muñoz: Brain-Dead Pregnant Woman Kept on Life Support to Incubate Fetus

In Texas, hospital officials refused to remove thirty-three-year-old Marlise Muñoz, a brain-dead woman, from life support for two months¹⁷⁵ because she was pregnant.¹⁷⁶ In November 2013, fourteen weeks into her pregnancy, Muñoz collapsed at home, likely from a blood clot that entered her lungs.¹⁷⁷ Shortly after receiving medical attention at the John Peter Smith Hospital in Fort Worth, Texas, doctors informed Muñoz's family that she had suffered brain death and would not recover.¹⁷⁸ However, instead of preparing to remove Muñoz's body from life support as requested by her husband, Eric Muñoz, and parents, Lynne and Ernest Machado, all of whom confirmed Muñoz herself would have so wished, hospital officials refused, citing a Texas law that prohibits health care providers from ending life support to pregnant patients.¹⁷⁹

Texas is one of more than two-dozen states that prohibit removing life support from a pregnant woman.¹⁸⁰ However, the Texas law is among the strictest in the nation. A dozen state statutes, including those of Kentucky, South Carolina, Texas, Utah, and Wisconsin, "automatically invalidate a woman's advance directive if she is pregnant."¹⁸¹ A study published by The Center for Women Policy Studies explains that these laws "are the most restrictive of pregnancy exclusion" legislation, because, regardless of fetal viability or the length of pregnancy, these laws require that a pregnant woman "remain on life sustaining treatment until she gives birth."¹⁸² These laws fit a pattern of politically motivated legislation that misuses pregnant women's medical crises as opportunities to legislate about reproduction. This type of legislation conflicts with pregnant women's fundamental constitutional interests, including autonomy, liberty, and privacy. For example, state legislation forcing a pregnant woman to carry a fetus to term directly conflicts with the constitutional precedent established in *Roe v. Wade* and interferes with

175. Manny Fernandez, *Texas Woman Is Taken Off Life Support After Order*, N.Y. TIMES, Jan. 26, 2014, <http://www.nytimes.com/2014/01/27/us/texas-hospital-to-end-life-support-for-pregnant-brain-dead-woman.html>.

176. Manny Fernandez & Erik Eckholm, *Pregnant, and Forced to Stay on Life Support*, N.Y. TIMES, Jan. 8, 2014, <http://www.nytimes.com/2014/01/08/us/pregnant-and-forced-to-stay-on-life-support.html>.

177. *Id.*

178. *Id.*

179. *Id.*

180. *Id.*

181. MEGAN GREENE & LESLIE R. WOLFE, PREGNANCY EXCLUSIONS IN STATE LIVING WILL AND MEDICAL PROXY STATUTES 3 (2012), available at http://www.centerwomenpolicy.org/programs/health/statepolicy/documents/REPRO_PregnancyExclusionsinStateLivingWillandMedicalProxyStatutesMeganGreeneandLeslieR.Wolfe.pdf.

182. *Id.*

a fundamental constitutional principle that guarantees each individual liberty.¹⁸³

The Center for Women Policy Studies highlights the lack of public awareness that FPLs exist and the problems that arise due to their enforcement.¹⁸⁴ Moreover, as there is virtually no uniformity in pregnancy exclusion laws,¹⁸⁵ they may be written under unrelated or confusing titles. In some states FPLs are written into statutes addressing advance directives; other states include them in statutes involving trusts and estates.¹⁸⁶ Thus, even the savviest pregnant women and their advocates may not be on notice about pregnancy exclusion legislation that ignores advance directives and explicit instructions about end of life care.

Even if mandatory life support laws were enacted as paternalistic protective measures for pregnant women and their fetuses, their application to a *dead* pregnant woman borders on the absurd. Ernest Machado lamented that his daughter had been reduced to “a host for a fetus.”¹⁸⁷ Until ordered to do otherwise, hospital officials had apparently planned to keep Muñoz’s body on life support until her fetus became viable, against the express wishes of her family members.¹⁸⁸ As Lynne Machado explained to a *New York Times* reporter, “It’s not a matter of pro-choice and pro-life,” rather, “It’s about a matter of our daughter’s wishes not being honored by the state of Texas.”¹⁸⁹

2. Angela Carder: Denying a Pregnant Patient Chemotherapy

As with Marlise Muñoz’s end of life tragedy, the deaths of Angela Carder and her fetus are a stark illustration of how doctors’ conscription into legal

183. *Roe* established abortion is within the scope of personal liberty guaranteed by the Due Process Clause. *Roe v. Wade* 410 U.S. 113 (1973). In the first trimester, the state cannot regulate or prohibit abortions. *Id.* In the second trimester, the state can regulate abortion to preserve and protect the woman’s health. *Id.* In the third trimester, the state can altogether prohibit abortions unless necessary to save the woman’s life. *Id.* Thus, although the right to an abortion is not absolute under *Roe*, it clearly established that the right to privacy includes a woman’s qualified right to an abortion and other reproductive decisions. *See id.* Since *Roe*, state laws and other Supreme Court cases have gradually tried to chip away at the rights established in *Roe*, such as requiring certain procedures before a woman can undergo an abortion. *See, e.g.*, TEX. HEALTH & SAFETY CODE ANN. § 171.012 (West 2011) (requiring a physician to perform and display an ultrasound to a woman before performing an abortion); *Gonzales v. Carhart*, 550 U.S. 124 (2007) (upholding a federal ban on a partial-birth abortion procedure known as “D&X”); *Planned Parenthood v. Casey*, 505 U.S. 833, 899 (1992) (upholding a requirement that unemancipated minors receive parental consent before an abortion).

184. GREENE & WOLFE, *supra* note 181, at 6.

185. “Pregnancy exclusion laws” refer to laws that require a woman’s advanced directive to be ignored if she is pregnant. *Id.* at 1.

186. *Id.* at 6.

187. Fernandez & Eckholm, *supra* note 176.

188. *See* Fernandez, *supra* note 175.

189. *Id.*

roles may undermine their exercise of medical judgment.¹⁹⁰ Carder, a cancer patient, developed a new and life-threatening tumor while pregnant; she sought chemotherapy treatment at the George Washington University Hospital.¹⁹¹ Carder's health rapidly deteriorated after being admitted as a cancer patient. At this point, Carder was close to death and chemotherapy provided the only chance she could survive until the twentieth-eighth week of pregnancy (when it would be somewhat safer to deliver the baby), but the treatment posed some medical risk to her twenty-six-week-old fetus.¹⁹² According to the D.C. Court of Appeals, "there was no evidence . . . showing that A.C. consented to, or even contemplated, a caesarean section before her twenty-eighth week of pregnancy."¹⁹³ In fact, testimony from Dr. Alan Weingold makes clear that Carder opposed the surgery:

THE COURT: You could hear what the parties were saying to one another?

DR. WEINGOLD: She does not make sound because of the tube in her windpipe. She nods and she mouths words. One can see what she's saying rather readily. She asked whether she would survive the operation. She asked [Dr.] Hamner if he would perform the operation. He told her he would only perform it if she authorized it but it would be done in any case. She understood that. She then seemed to pause for a few moments and then very clearly mouthed words several times, *I don't want it done. I don't want it done.* Quite clear to me.¹⁹⁴

Dr. Weingold further explained to the Court: "I would obviously state the obvious and that is this is an environment in which, from my perspective as a physician, this would not be an informed consent one way or the other. . . . I'm satisfied that I heard clearly what she said."¹⁹⁵

Despite this and her family's opposition, doctors and hospital officials intubated Carder and petitioned the Superior Court of the District of Columbia to authorize an immediate cesarean operation.¹⁹⁶ After adopting the hospital's recommendation, the "court ordered that a caesarean section be performed to deliver A.C.'s child."¹⁹⁷ Notwithstanding Carder's counsel immediate request

190. See *In re A.C.*, 573 A.2d 1235, 1237 (D.C. 1990) (holding that when a pregnant patient is near death and her fetus is viable, the decision of what is to be done is to be decided by the patient, unless incompetent).

191. *Id.* at 1238. See also Terry E. Thornton & Lynn Paltrow, *The Rights of Pregnant Patients: Carder Case Brings Bold Policy Initiatives*, 8 HEALTHSPAN 10 (1991) (noting that "Angela . . . decided to institute aggressive treatment of her cancer").

192. *In re A.C.*, 573 A.2d at 1238-39.

193. See *id.* at 1239.

194. *Id.* at 1240-41.

195. *Id.* at 1241.

196. *Id.* at 1257.

197. *Id.* at 1240.

for a stay, “a hastily assembled” panel consisting of three D.C. Court of Appeals judges denied the proposed injunction.¹⁹⁸

Following Carder’s court-ordered cesarean operation, her baby survived for two hours and Carder died two days later without receiving the cancer treatment she sought.¹⁹⁹ On appeal after her death, however, the D.C. Court of Appeals held that “in virtually all cases the question of what is to be done is to be decided by the patient . . . on behalf of herself and the fetus.”²⁰⁰

The medical personnel’s extreme actions in Carder’s case, though shocking, are sadly not unique. In 2004, Pennsylvania doctors obtained a court order to force Amber Marlowe to deliver by cesarean section, because ultrasound imaging indicated that her baby might weigh as much as thirteen pounds.²⁰¹ Marlowe’s case highlights another angle of the FPL problem, the paternalist rejection of women’s ability to know their own bodies and make medical decisions for themselves and their pregnancies. In that case, the court order granted Marlowe’s doctors and the hospital the authority to perform a nonconsensual cesarean operation.²⁰² Marlowe, the mother of six—who were all big babies—fled the hospital and later delivered a healthy eleven-pound baby girl at another hospital. In a subsequent interview, Marlowe confided, “[W]hen I found out about the court order, I couldn’t believe the hospital would do something like that. It was scary and very shocking.”²⁰³

The scope of the problems identified here—physicians prioritizing fetal health over maternal health and decision making based on legislative, law enforcement, and political pressure²⁰⁴—are difficult to track as not all cases of

198. *Id.* at 1238.

199. *Id.*

200. *Id.* at 1237; Thornton & Paltrow, *supra* note 191; see also Veronika E.B. Kolder et al., *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192 (1987) (discussing a national survey of the scope of court-ordered obstetrical procedures in cases in which the woman refused therapy deemed necessary for the fetus).

201. David Weiss, *Court Delivers Controversy: Mom Rejects C-Sections; Gives Birth on Own Terms*, TIMES LEADER, Jan. 16, 2004, at 1A.

202. *Id.*

203. Lisa Collier Cool, *Could You Be Forced to Have a C-Section*, BABY TALK MAG., May 2005, http://advocatesforpregnantwomen.org/articles/forced_c-section.htm.

204. “Project Prevention: Children Require a Caring Community (“CRACK”)” is one such activist group whose website states that its main objective “is public awareness to the problem of drug addicts/alcoholics exposing their unborn child to drugs during pregnancy.” *Objectives*, PROJECT PREVENTION, <http://www.projectprevention.org/objectives/> (last visited Apr. 9, 2014). Barbara Harris is the founder of CRACK, which offers \$200 to any drug-addicted or alcoholic mother who agrees to be sterilized or have Norplant implanted. It also offers \$200 to male drug addicts or alcoholics who agree to have a vasectomy. Jeff Stryker, *Cracking Down*, SALON (July 10, 1998 3:25 AM), http://www.salon.com/1998/07/10/cov_10feature/. In her discussion on pregnant drug-users, Harris states that “If they are drug addicts, they are drug addicts by choice. . . . People say it is a disease, fine. But it is a disease of choice—however they go there and whatever their background and however screwed up their life is. The babies don’t have a choice.” *Id.* She further states that “these women are literally having litters of children” and that they are “not acting any more responsible than a dog in heat.” *Id.*

compelled cesarean operations, confinement, or arrest are afforded judicial review or a written opinion when a court was involved. Nevertheless, the collateral consequences that flow from even this small sample of cases cause serious alarm. Indeed, each of these cases is “capable of repetition.”²⁰⁵ And, this phenomenon illumines a serious corruption of the physician-patient relationship.

Indeed, as the following section explores, asking doctors and nurses to enforce FPLs not only results in poor legal decision making and compromised medical judgment, it fundamentally distorts the fiduciary nature of the physician-patient relationship, which emphasizes self-determination, informed consent prior to any surgical intervention offered to a patient, the right to refuse medical care, and the right to privacy, among other legal protections.

II.

THE FIDUCIARY RELATIONSHIP, CRIMINAL LEVERAGE, AND MEDICAL UTILITY

Noticeably absent in the operation of contemporary fetal protection efforts are these foundational, internationally-agreed-upon bioethics principles: informed consent, autonomy, social justice, and voluntary participation.²⁰⁶ The earliest collective iteration of these principles derived from the adjudicative process in the criminal trials of Nazi doctors at Nuremberg. These doctors’ deliberate disregard for the health and safety of nonconsenting human subjects in their research studies on sterilization,²⁰⁷ serology,²⁰⁸ human survival under distressing conditions,²⁰⁹ and mastery of euthanasia²¹⁰ resulted in deaths and severe disabilities among survivors.²¹¹ The Nuremberg Doctors’ Trial

205. James, *supra* note 54.

206. See 2 Trials of War Criminals Before the Nuremberg Tribunals Under Control Council Law No. 10 189, 237 (1949) [hereinafter Nuremberg Code]; 18TH WORLD MEDICAL ASSOCIATION GENERAL ASSEMBLY, DECLARATION OF HELSINKI: ETHICAL PRINCIPLES FOR MEDICAL RESEARCH INVOLVING HUMAN SUBJECTS (1964) [hereinafter *Declaration of Helsinki*], available at <http://www.wma.net/en/30publications/10policies/b3/17c.pdf>.

207. See Steven Greenhouse, *Capturing the Cost of Atrocity: Survivor of Nazi Experiments Says \$8,000 Isn't Enough*, N.Y. TIMES, Nov. 19, 2003, <http://www.nytimes.com/2003/11/19/nyregion/capping-the-cost-of-atrocity-survivor-of-nazi-experiments-says-8000-isn-t-enough.html?pagewanted=all&src=pm>.

208. See Isabel Wilkerson, *Nazi Scientists and the Ethics of Today*, N.Y. TIMES, May 21, 1989, <http://www.nytimes.com/1989/05/21/us/nazi-scientists-and-ethics-of-today.html>.

209. See, e.g., Peter Tyson, *The Experiments*, PBS: NOVA ONLINE, <http://www.pbs.org/wgbh/nova/holocaust/experiside.html> (last visited Apr. 9, 2014).

210. Paul Weindling, *Human Experiments and Nazi Genocide: a Problematic Legacy*, 1 REV. OF BIOETHICS, Autumn 2007 / Winter 2008, at 1, 5, available at http://bioethicsreview.uoc.gr/Vol1/Issue1/v1i1ael_Weindling.pdf (noting that the “Robert Koch Institute carried out unethical research in the fields of serology, and malaria, tuberculosis, typhus, typhoid and plague research”).

211. American and international medical ethics are rooted in the collapse of Nazi Germany and the subsequent trials at Nuremberg, where Third Reich physicians and researchers revealed the mass horrors of their human experimentation and broader brutality in the quest for scientific knowledge. NAZI DOCTORS AND THE NUREMBERG CODE 97–100 (George J. Annas et al. eds., 1992) (discussing a variety of the experiments conducted by the Nazis, which often involved “grave injury,

contributed to the articulation and establishment of universally recognized human rights principles in law and medicine that specify doctors' fiduciary duties and form the ethical framework for the physician-patient relationship.²¹²

Originally, these principles defined the general standard for medical experimentation on human subjects. However, as described below, they now cohere to form the basis of physicians' fiduciary obligations to patients, namely that voluntary consent is an essential component of any medical treatment;²¹³ confidentiality is paramount to the physician-patient relationship and should not be trespassed by health care providers;²¹⁴ medical treatments should avoid subjecting patients to unnecessary suffering, including, but not limited to

torture, and ill-treatment"); *Nuremberg Code*, *supra* note 206, at 181–82; George J. Annas, *The Legacy of the Nuremberg Doctors' Trial to American Bioethics and Human Rights*, 10 MINN. J.L. SCI. & TECH. 13, at 20–21 (2009); Steven Greenhouse, *Capping the Costs of Atrocity: Survivor of Nazi Experiments Says 8,000 Isn't Enough*, N.Y. TIMES, Nov. 19, 2003, <http://www.nytimes.com/2003/11/19/nyregion/capping-the-cost-of-atrocity-survivor-of-nazi-experiments-says-8000-isn-t-enough.html?pagewanted=all&src=pm>.

212. See Annas, *supra* note 211, at 20–21. The Nuremberg Doctors' Trial (one of thirteen criminal trials at Nuremberg) was conducted by the International Military Tribunal at Nuremberg and presided over by an international panel of judges. It began in 1946 and concluded in 1947. *Id.*

213. Informed consent for medical treatment, particularly surgery, is well founded in American law. *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914). Dating back more than a century, U.S. courts established that express or implied consent must be granted by patients prior to surgery. Justice Cardozo's famous dictum, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages" highlights the standard for informed consent in a case where a female patient claimed that doctors removed a tumor from her uterus against her will and without regard to her specific instructions prohibiting them from doing so. *Id.* But see Paul Lombardo, *Phantom Tumors and Hysterical Women: Revising our View of the Schloendorff Case*, J.L. MED. & ETHICS 791, 793 (2005) (noting that the *Schloendorff* case may not have represented the sea change portended by Cardozo's "ringing pronouncement" until the 1950s when New York declined to recognize charitable immunity for a hospital).

214. The principle to preserve patient confidence is distilled in law and ethics. The American Medical Association offers this clear statement on the issue: "[t]he physician should not reveal confidential information without the express consent of the patient." American Medical Association, *Opinion 5.05: Confidentiality*, AMA CODE OF MED. ETHICS, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion505.page?> (last visited Apr. 18, 2014). In limited cases where an exception is enforced by law or court order, the Association cautions that the physician should notify her patient and only "disclose the minimal information required by law, advocate for the protection of confidential information." *Id.* See also The Privacy Rule established by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") hazards against medical providers disclosure of individuals' health information. 45 C.F.R. § 164 (providing HIPAA's "Security and Privacy" requirements). Courts have also recognized the right to confidentiality as distinct, but complimentary to the privacy right to control one's information. See generally *Whalen v. Roe*, 429 U.S. 589, 599–600 (1977) (noting that privacy rights encompass two distinct spheres: an individual's interest in independent decision-making and an interest in avoiding or refusing disclosure of intimate information, including medical records); *Eisenstadt v. Baird*, 405 U.S. 438, 450 (1972) ("If the right of privacy means anything, it is the right of the individual . . . to be free from unwanted governmental intrusions into matters so fundamentally affecting a person as the decision whether to bear or beget a child."). But see *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334, 349–51 (Cal. 1976) (imposing a duty to warn in a case where an imminent threat of harm to a third party is substantially likely to occur). Importantly, *Tarasoff* involved the stalking and murder of a college student, not a risk of harm to a fetus. *Id.*

unnecessary reproductive surgeries,²¹⁵ and patients must be at liberty to withdraw from medical treatment, even if rejecting medical assistances might result in their deaths.²¹⁶

A. The Fiduciary Relationship in Common Law: A Bundle of Principles, Obligations, and Rights

The modern fiduciary relationship between health care providers and their patients represents a complex set of physician obligations that flow to their patients as a bundle of rights. Courts explain that the fiduciary relationship demands an important level of care, confidence, and loyalty across a broad sphere of physician-patient interactions.²¹⁷ As one court stated decades ago, “[t]he courts frequently state that the relationship between the physician and his patient is a fiduciary one,” creating in the physician “an obligation to make a full and frank disclosure to the patient of all pertinent facts related to his illness.”²¹⁸ For example, the California Court of Appeals, likely the first court to adopt the legal criterion of “informed consent” (replacing a general consent

215. See *Hundley v. St. Francis Hosp.*, 327 P.2d 131, 136 (Cal. Dist. Ct. App. 1958) (holding that a “jury could find that it is not accepted surgical practice to remove [the uterus] when there are no pathological abnormalities.”); see also *Steele v. St. Paul Fire & Marine Ins. Co.*, 371 So. 2d 843 (La. Ct. App. 1979) (holding that the patient unnecessarily suffered the “removal of a health organ of her body, i.e., her uterus and the unnecessary loss of her childbearing potential.”); *Thimatariga v. Chambers*, 416 A.2d 1326 (Md. Ct. Spec. App. 1980) (affirming a jury award of \$1,200,000 in a case involving a nonconsensual hysterectomy”). More recently, significant settlements have been awarded in cases where plaintiffs successfully allege unnecessary hysterectomies. See *\$5M Settlement in Hysterectomy Trial*, ABC NEWS (Sept. 17, 2009), <http://abclocal.go.com/wls/story?section=news/local&id=7019803> (reporting a significant settlement in a medical case involving an unnecessary hysterectomy).

216. In *Wons v. Public Health Trust of Dade County*, 500 So. 2d 679, 679 (Fla. Dist. Ct. App. 1987), the Florida Court of Appeals ruled that a competent adult woman possesses the lawful right to refuse blood transfusions even when she might die and leave behind minor children. In that case, the court ruled “the state has no compelling interest under the circumstances of this case sufficient to override the patient’s constitutional right (a) to practice her religion according to her conscience, and (b) to lead her private life free from unreasonable government interference.” *Id.* See also *In re Brown*, 478 So. 2d 1033, 1036 (Miss. 1985) (finding that a patient’s right to reject a life-saving blood transfusion is “the individual’s protection against the tyranny of the majority and against the power of the state”). In fact, decades prior to Nuremberg, by the early 1900s, “the expectation that the consent of patients was required before treatment was well settled” in law. Lombardo, *supra* note 213, at 798.

217. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 782 (D.C. Cir. 1972) (“The patient’s reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with arms-length transactions.”); *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 483 (Cal. 1990) (holding research physician must disclose conflicting financial interest to patient); *Salgo v. Leland Stanford Jr. Univ. Bd. of Trs.*, 317 P.2d 170, 181 (Cal. Ct. App. 1957); Charity Scott, *Why Law Pervades Medicine: An Essay on Ethics in Health Care*, 14 NOTRE DAME J.L. ETHICS & PUB. POL’Y 245, 264 (2000) (“Since the early part of this century, the law has expressed society’s view that it was wrong—a violation of autonomy—to treat the patient without some kind of consent.”).

218. *Natanson v. Kline*, 350 P.2d 1093, 1101, 1104 (Kan. 1960) (“Anglo-American law starts with the premise of thorough-going self-determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment.”).

standard), clarified that “[a] physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment.”²¹⁹ The Minnesota Supreme Court issued a similar rule in 1958. The court explained that while it did not wish to burden the medical profession and its progress, physicians were nevertheless obligated to inform patients about their medical treatment, including less invasive surgical alternatives, in order to allow the patient to decide whether to live with the “serious consequences” of refusing medical care.²²⁰

The legal rights that provide a sanctuary for patients should be no less protective of pregnant women who wish to be informed about medical options, including the refusal of care. The premise of U.S. laws in this field is the right to self-determination. U.S. law emphasizes that each patient is the master of her own body with the authority to grant a physician the license to treat a condition or to refuse medical interventions and therapies.²²¹ This foundational legal principle serves as the basis of other patient rights and constraints on health care providers. Notably, a physician’s duties to inform patients about risks and benefits of a given medical treatment,²²² disclose potential conflicts of interests,²²³ safeguard confidences,²²⁴ and perform medical duties with

219. *Salgo*, 317 P.2d at 181.

220. *Bang v. Charles T. Miller Hosp.*, 88 N.W.2d 186, 190 (Minn. 1958).

221. *Davis v. Hubbard*, 506 F. Supp. 915, 930 (N.D. Ohio 1980) (explaining “there is perhaps no right which is older than a person’s right to be free from unwarranted contact”); *Natanson*, 350 P.2d at 1104 (holding that law does not permit a physician to substitute her judgment for that of the patient). Only narrow exceptions render the patient’s voice mute on the subject of autonomous decision-making, such emergency or lack of capacity to consent to medical treatment. *Cunningham v. Yankton Clinic, P.A.*, 262 N.W.2d 508, 511 (S.D. 1978).

222. *Salgo*, 317 P.2d at 181.

223. *See, e.g., Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 483 (Cal. 1990).

224. The South Carolina Supreme Court compared the medical ethics requirement in that state to the professional standards imposed on lawyers. *See S.C. Bd. of Med. Examiners v. Hedgepath*, 480 S.E.2d 724, 726 n.2 (S.C. 1997). In this case, the South Carolina Supreme Court reinstated a doctor’s censure by the South Carolina State Board of Medical Examiners for breaching the duty to maintain his patient’s confidences. *See also Hammonds v. Aetna Cas. & Sur. Co.* 243 F. Supp. 793, 801 (N.D. Ohio 1965) (ruling “this court is of the opinion that the doctor warrants that any confidential information gained through the relationship will not be released without the patient’s permission”); *MacDonald v. Clinger*, 84 A.D.2d 482, 487 (N.Y. App. Div. 1982) (ruling “[d]efendant’s breach was not merely a broken contractual promise but a violation of a fiduciary responsibility to plaintiff implicit in and essential to the doctor-patient relation” when he provided the patient’s wife confidential information); *Doe v. Roe*, 400 N.Y.S.2d 668, 678 (Sup. Ct. 1977) (finding liability was “clear” when a doctor disclosed patient’s confidential psychological information) (“[A]lmost every member of the public is aware of the promise of discretion contained in the Hippocratic Oath, and every patient has a right to rely upon this warranty of silence.”); *McCormick v. England*, 494 S.E.2d 431, 435–36 (S.C. Ct. App. 1994) (stating that “[a] majority of the jurisdictions faced with the issue have recognized a cause of action against a physician for the unauthorized disclosure of confidential information unless the disclosure is compelled by law or is in the patient’s interest or the public interest”); *Berry v. Moench*, 331 P.2d 814, 817 (Utah 1958) (ruling that “if the doctor violates . . . confidence and publishes derogatory matter concerning his patient, an action would lie for any injury suffered”). Even as against the state and other entities, courts have upheld patient information privacy rights. *See*

competence and care²²⁵ give rise to enforceable legal obligations vital to the interests of her patients.²²⁶ This bundle of rights includes the basic “natural right” to be left alone.²²⁷

The U.S. Supreme Court underscored the importance of the physician-patient relationship and the significance of loyalty, trust, and confidence in *Jaffe v. Redmond*. Here, the Court explained that “the mere possibility of a therapist’s disclosure may impede development of the confidential relationship necessary for successful treatment.”²²⁸ The Court ruled that “protecting confidential communications between a psychotherapist and her patient” sufficiently promoted important interests.²²⁹ The Court compared the patient’s private communications with her therapist to the protected speech between spouses and attorneys with their clients,²³⁰ ruling that the conversations and notes exchanged between an officer who shot and killed a man during the course of responding to a “fight in progress” and her therapist were protected from compelled disclosure.²³¹

Federal law further clarifies and codifies confidentiality requirements among some medical professionals, including federally funded drug treatment programs, prohibiting such organizations from divulging patient records. For example, federal law prohibits the disclosure of:

The [records], identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of

Eisenstadt v. Baird, 405 U.S. 438, 453 (1972) (stating that “[i]f the right of privacy means anything,” according to Justice Brennan, “it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision to whether to bear or beget a child”).

225. *Howard v. Univ. of Med. & Dentistry of N.J.*, 800 A.2d 73, 77 (N.J. 2002) (noting the duty of care is an evolved standard originating in battery and now evolved to negligence).

226. For example, as early as 1905, a state supreme court affirmed an award of damages to a patient after she challenged a doctor’s nonconsensual surgery, which she claimed caused hearing loss. *Mohr v. Williams*, 104 N.W. 12, 16 (Minn. 1905). Anna Mohr argued that while she had granted consent for surgery, license to operate was limited to her right ear and not the left. In upholding the trial court’s award, the Minnesota Supreme Court opined that “every person has a right to complete immunity of his person from physical interference of others, except in so far as contact may be necessary under the general doctrine of privilege.” *Id.* Justice Brown proclaimed that “any unauthorized touching of the person of another . . . constitutes an assault and battery,” including in the medical context. *Id.*

227. The *Mohr* court articulated a general principle that “the patient must be the final arbiter as to whether he will take his chances with the operation, or take his chances living without it.” *Id.* See also *Pratt v. Davis*, where the Illinois Supreme Court, affirmed the lower court ruling in a lawsuit alleging that a doctor performed a nonconsensual hysterectomy on his patient. The court ruled that “it is manifest” that a patient’s consent “be a prerequisite to a surgical operation.” 79 N.E. 562, 564 (Ill. 1906).

228. *Jaffe v. Redmond*, 518 U.S. 1, 10 (1996).

229. *Id.* at 9. The Court also recognized that the privilege should extend to social workers. *Id.* at 15.

230. *Id.* at 10 (noting that “like the spousal and attorney-client privileges, the psychotherapist-patient privilege is rooted in the imperative need for confidence and trust”).

231. *Id.* at 4, 18.

any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States.²³²

In a special section on criminal proceedings, the federal law further emphasizes, “No record . . . may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.”²³³ Not only have courts and Congress issued clear pronouncements about the legally enforceable fiduciary duties placed on doctors, so too have state legislatures,²³⁴ medical boards,²³⁵ and professional organizations.²³⁶ National professional medical organizations stress the value and importance of physicians’ prioritizing their patients’ needs above all else, including law enforcement. The American Medical Association (AMA) and the American Public Health Association (APHA)²³⁷ offer unequivocal statements that the role of doctors

232. 42 U.S.C. § 290dd–2(a) (1998).

233. 42 U.S.C. § 290dd–2(c).

234. All fifty states and the District of Columbia have enacted laws privileging the communications between psychotherapists and their patients. *See Jaffe*, 518 U.S. at 12 n.11 (listing each state’s psychotherapist privilege statute).

235. In 2013, the North Dakota State Board of Medical Examiners issued a stinging censure against a doctor for breaching patient confidence to an insurer, referring to the physician’s actions as “engaging in conduct that is dishonorable, unethical . . . and that is likely to deceive, defraud, or harm the public.” The Board further noted that “breaching the confidentiality between physician and patient is proscribed” by North Dakota statutes. *N.D. State Bd. of Med. Examiners v. Wynkoop*, OAH File No. 20130085 (Nov. 22, 2013), available at https://www.ndbomex.org/news/board_orders.asp (ordering that “if Respondent shall fail, neglect or refuse to comply with any of the terms, provisions, or conditions herein, the license of the Respondent . . . should automatically be suspended . . .”). In another 2013 case, the Board of Medical Examiners suspended the license of a physician who accessed the medical records of an individual who was not her patient and found that this action violated that individual’s physician-patient confidentiality. *N.D. State Bd. of Med. Examiners v. Albertson* (Nov. 22, 2013), available at https://www.ndbomex.org/news/board_orders.asp (issuing a one-year license suspension stayed if upon the completion of completion of ethics course). *See also In re Sudol*, OIE No. 2009.5 (Dec. 9, 2009) (South Carolina Medical Examiners concluding that a therapist violated statutory provisions “by engaging in unethical and unprofessional behavior when she divulged confidential information without appropriate permission”).

236. The National Medical Association, Association for Medical Education, South Carolina Medical Association, the American College of Obstetricians and Gynecologists, and the American Nurses Association were among the organizations to join an amicus brief in *Ferguson v. Charleston*. Brief for Am. Pub. Health Ass’n et al. as Amici Curiae in Support of Petitioner, *Ferguson v. Charleston*, 532 U.S. 67 (2001) (No. 99-936), 2000 WL 33599645 [hereinafter Brief for APHA et al. for Petitioner].

237. *Id.* at Appendix (explaining that Amicus South Carolina Medical Association “opposes policies and practices that undermine patient confidentiality and weaken the trust between health care providers and patients that promotes positive treatment outcomes”). In the brief’s Appendix, the American Society of Addiction Medicine emphasized that it “staunchly opposes policies that create obstacles to or deter persons from receiving substance abuse treatment and counseling.” *Id.* The Society of General Internal Medicine warned, “[T]he failure to maintain proper patient confidentiality (at the heart of MUSC’s policy) will not only discourage women from seeking this vital care but may well interfere with physicians ability to provide it when sought.” The American Nurses Association cautioned that it “is concerned that when health care providers divulge patient information to law enforcement officials[,] women in need of prenatal care and/or substance abuse treatment are deterred

and nurses must be first and primarily to serve patients' needs and not law enforcement goals.²³⁸ These medical organizations justifiably caution against states' efforts to conscript physicians and nurses into serving as informants because it confuses the role of health care providers, misleads patients without providing any notice, and potentially chills the physician-patient relationship.

If fiduciary duties are so well ensconced within the law, what could possibly justify the dilution or abandonment of legal and ethical obligations by doctors in cases involving pregnant patients?²³⁹ Professor Michelle Oberman explains that a double standard has always existed in the context of pregnancy whereby doctors view not one, but "two lives involved."²⁴⁰ She astutely warned that doctors who embrace this view in the name of pregnancy ultimately propose that "women should have fewer rights than do their male counterparts."²⁴¹ Furthermore, Oberman argued that this is a "legally and ethically obsolete premise."²⁴² However, fetal protection cases described in this Article—many not envisaged even fifteen years ago—now challenge whether those premises really are outmoded. As the next section illustrates, contemporary fetal protection cases demonstrate a bold abrogation of even those fiduciary standards currently established by courts and the medical profession. The institutional shifts that imbed doctors as criminal law gatekeepers have led to the abdication of their legal fiduciary duties to their pregnant patients, perhaps to protect their medical licenses, despite the fact that trust and loyalty remain vital to the physician-patient relationship.²⁴³

B. Formidable Discretionary Power: FPLs Lead to the Corruption of the Physician-Patient Relationship

*Ferguson v. Charleston*²⁴⁴ represents a shift in the role of medical staff from serving the needs of patients to gathering medical evidence for the state to use against them. In that case, ten women initiated Section 1983 civil rights

from seeking these essential services." *Id.* These were a few of the organizations, among other organizations and many individual physicians, who joined the amicus brief.

238. *See id.* at 3; Brief for the Am. Med. Ass'n as Amicus Curiae in Support of Neither Party, *Ferguson v. Charleston*, 532 U.S. 67 (2001) (No. 99-936), 2000 WL 1506967; *see also* Goodwin, *supra* note 62.

239. Michelle Oberman rightly frames these dynamics as extending beyond maternal fetal conflicts to a new landscape riddled by patient-physician conflicts. She argues that it may be "doctors' seemingly well-motivated efforts to promote maternal or fetal well-being" that induces physicians to impose "their perceptions of appropriate medical care on their pregnant patients." Michelle Oberman, *supra* note 12, at 454.

240. Oberman, *supra* note 12, at 469–70 (citing WILLIAMS J. WHITRIDGE, WILLIAMS OBSTETRICS (Jack Pritchard & Paul MacDonald eds., 16th ed. 1980). Oberman further notes that feminists and others have invested in this framework "in contexts ranging from the employment setting to efforts to secure women's rights to abortion." *Id.* at 470.

241. *Id.* at 471.

242. *Id.*

243. *See Jaffee v. Redmond*, 518 U.S. 1, 10 (1997).

244. 532 U.S. 67 (2001).

litigation²⁴⁵ against the Medical University of South Carolina (MUSC) and local government officials, claiming that they were the victims of warrantless and nonconsensual searches initiated and performed by medical staff.²⁴⁶ Medical officials at MUSC volunteered to serve as informants against their patients²⁴⁷ and initiated contact with a local prosecutor, Charles Condon, upon learning that he campaigned to extend child abuse laws to the use of drugs by pregnant women.²⁴⁸ Condon established an interagency task force, which included police, the prosecutor's office, and hospital staff.²⁴⁹ Together, they created what plaintiffs called the "Search Policy."²⁵⁰ In a series of memoranda and meetings, Condon and his team informed medical personnel how to collect urine samples for use in criminal investigations and protect the samples' "chain of custody," and devised the method by which MUSC staff would report to police.²⁵¹ Law enforcement staff trained the doctors and nurses, and Condon provided written guidance "listing criminal charges that could apply to women coming under the Search Policy."²⁵²

Medical staff at MUSC along with police and prosecutors "disproportionately targeted indigent, African American women for search and arrest."²⁵³ In their search program, of the thirty women arrested, twenty-nine were African American.²⁵⁴ Special dispensation was sought for at least one white woman who met the criteria for arrest but remained free.²⁵⁵ Racial profiling may have contributed to the arrest of another white woman because a nurse and member of the interagency task force made a point of notating the patient's chart with the following information: "Patient live[s] with her boyfriend who is a Negro."²⁵⁶ While this notation did not serve any medically relevant purpose, it does reveal that an illicit extralegal consideration—race—was involved in the implementation and enforcement of South Carolina's FPL.²⁵⁷ This particular nurse admitted at trial that she believed interracial

245. 42 U.S.C. § 1983 allows citizens to file suit for money damages against [e]very person who, under color of any statute, ordinance, regulation, custom, or usage, of any State . . . subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws. 42 U.S.C. § 1983 (1996).

246. *Id.* at 73.

247. *Id.* at 70–71.

248. Brief for Petitioners at 2–3, *Ferguson v. Charleston*, 532 U.S. 67 (2001) (No. 99–936).

249. *Id.* at 2.

250. *Id.*

251. *Id.* at 4.

252. *Id.*

253. *Id.* at 12.

254. *Id.* at 13.

255. *Id.* at 12 (noting "Nurse Brown admitted that she called the Solicitor's office and requested another "chance" on behalf of a white patient who should have been arrested under the Policy's terms").

256. *Id.* at 13 n.10.

257. *Id.* ("The record demonstrates that Nurse Brown, who helped establish the Search Policy and was integral to its everyday implementation, held racist views.").

relationships violated “God’s way,”²⁵⁸ and “raised the option of sterilization for black women testing positive for cocaine, but not for white women.”²⁵⁹ This search process introduced a level of unusual cruelty into the delivery of medicine, altering a common understanding about hospitals providing safety, comfort, and respite to those seeking medical help. As transcripts in the case reveal, some women subjected to arrest were “denied the opportunity to change from their hospital gowns or to make a phone call to family members to make arrangements for the care of their children.”²⁶⁰ In other instances, police apprehended the new mothers “while still bleeding, weak and in pain from having just given birth.”²⁶¹ Some were handcuffed and shackled, with chains circling their abdomen. Leg irons were used in some cases.²⁶² For any woman who could not walk, “a blanket or sheet would be placed over the woman, and she would be wheeled out of the hospital to a waiting police car and transported to jail.”²⁶³

The collaboration between MUSC medical staff and law enforcement to obtain incriminating evidence against pregnant women seeking prenatal care exposes a provocative example of physicians wielding significant discretion in the furtherance of a criminal law purpose rather than serving patients’ medical interests.²⁶⁴ Despite an ultimate vindication for the *Ferguson* petitioners, fetal protection prosecutions appear to be on the rise, leading to the arrest and imprisonment of a broad spectrum of pregnant women and new mothers.²⁶⁵ In Bei Bei Shuai’s case, she was arrested and faced a first degree murder charge with a possible sentence of forty-five years to life in prison for the death of her newborn after a failed suicide attempt while pregnant.²⁶⁶ Shuai’s subsequent plea deal in 2013²⁶⁷ spared her a gruesome and unjust fate, but not before arrest, over a year of incarceration, and public humiliation. In another case, a member of a fundamentalist religious community was arrested for refusing medical care during her pregnancy.²⁶⁸ The threats of law enforcement and civil

258. *Id.* at 12.

259. *Id.*

260. *Id.* at 17.

261. *Id.*

262. *Id.*

263. *Id.*

264. *See id.* at 12 (“As the Medical Director of the Neonatal Intensive Care Unit testified, testing was not being done for medical reasons, but solely for purposes of the Search Policy.”).

265. *See* Eckholm, *Fetus versus Mother*, *supra* note 29.

266. Associated Press, *Chinese Immigrant Pleads Guilty in Baby’s Death*, ABC NEWS (Aug. 2, 2013), available at <http://abcnews.go.com/m/story?id=19858146&sid=81>; Ed Pilkington, *Indiana Prosecuting Chinese Woman for Suicide Attempt that Killed Her Foetus*, GUARDIAN (May 30, 2012, 1:36 PM), <http://www.guardian.co.uk/world/2012/may/30/indiana-prosecuting-chinese-woman-suicide-foetus>.

267. Associated Press, *Chinese Immigrant Pleads Guilty in Baby’s Death*, *supra* note 266.

268. Rebecca Corneau was taken into custody and confined to a secure hospital after she refused to submit to a court-ordered medical exam to evaluate her and her fetus’s health. *See* Dave

confinement now extend to women who refuse cesarean birth, preferring natural births instead.²⁶⁹ Medical personnel's exercise of judgment is critical to these arrests.

The discretionary power described above, much like that afforded prosecutors or police officers, can be corruptible and vulnerable to selective, but largely unchecked enforcement, social bias, political ideology, and prejudice.²⁷⁰ This is particularly worrisome in physician-patient contexts because doctors and nurses enjoy inimitable access to patients' medical, social, and personal histories.²⁷¹ Yet, unlike police and prosecutors, doctors do not receive legal training to understand patients' constitutional rights or their legal duty to avoid racial profiling. There is no "detached scrutiny" of a neutral authority or judge to assess the permissibility of doctors gaining access to patient information for law enforcement purposes. No legal authority supervises the subjective dealings of doctors who may use the veil of medicine to obtain information for nonmedical purposes. By contrast, police cannot sign their own search warrants and for good reason. Justice Brandeis explained that the "greatest dangers to liberty lurk in the insidious encroachment by men of zeal, well-meaning, but without understanding."²⁷²

Ensnaring doctors into quasi-agent roles circumvents legal process and deceives patients because pregnant women lack notice and warning that their prenatal visit with their physicians may also serve as a potential criminal investigation. The Supreme Court has ruled that in criminal investigations, suspects in police custody must be warned of their right not to self-incriminate lest their constitutional rights be violated.²⁷³ A corollary principle does not exist in medicine; there is no medical "Miranda Warning." However, that wise logic should prevail in medical cases, too. When individuals encounter police, they are on notice about the potential to fall under the criminal gaze. This is not true with doctors.

It should also be alarming that in *Ferguson*, medical staff lured women into a legal trap under the pretense of providing medical services. In Darlene

Wedge, *Judge Confines Cult Mom to Secure Hospital*, BOS. HERALD, Sept. 1, 2000, available at 2000 WLNR 227248.

269. Letitia Stein, *USF Obstetrician Threatens to Call Police if Patient Doesn't Report for C-Section*, TAMPA BAY TIMES, Mar. 6, 2013, <http://www.tampabay.com/news/health/usf-obstetrician-threatens-to-call-police-if-patient-doesnt-report-for/2107387>.

270. See Brief of the NARAL Foundation et al. as Amici Curiae in Support of Petitioners, *Ferguson v. Charleston*, 532 U.S. 67 (2001) (No. 99-936), 2000 WL 1506972, at *23-*26 for a discussion about how discretionary power was abused and subjectively applied. See also Dwight L. Green, *Abusive Prosecutors: Gender, Race & Class Discretion and the Prosecution of Drug-Addicted Mothers*, 39 BUFF. L. REV. 737, 738 (1991) (stating that prosecutorial discretion can lead to biased law enforcement because "[p]rosecutors reflect the unstated but operative norms in American courtrooms, which are predominantly affluent, white, usually male, and often Protestant perspectives"); Song Richardson, *Arrest Efficiency and the Fourth Amendment*, 95 MINN. L. REV. 2035 (2011).

271. *Jaffee v. Redmond*, 518 U.S. 1, 10 (1996).

272. *Olmstead v. United States*, 277 U.S. 438, 479 (1928) (Brandeis, J., dissenting).

273. *Miranda v. Arizona*, 384 U.S. 436, 478-79 (1966).

Nicholson's case, the lead nurse searched her urine under the guise of medical treatment for hydration and threatened arrest after a positive urinalysis:

They said I was dehydrated and I needed to be hooked up to glucose. . . . They told me to drink lots of water. . . . I asked them if I was to be hooked up to the glucose machine. . . . They just told me to keep drinking water . . . and told me to use the bathroom in a cup. . . . And I asked what for and they said to see if I had enough fluid in my system so they could send me home.²⁷⁴

Court documents reveal the extent of deception, threat, and entrapment: Sandra Powell went to MUSC in labor but was informed that because of a positive urinalysis for cocaine, she would be arrested immediately. When Powell pleaded for medical help by saying “please, what could I do to stop this or could you help me,” the nurse “responded simply that she would ‘be locked up.’”²⁷⁵ The Plaintiff's Brief and exhibit explain that Powell was arrested, while “still in pain and bleeding from childbirth,” wearing only a hospital gown during her transport to jail.²⁷⁶ That patients arrested during the Search Policy's early months did not receive drug treatment referral and “no opportunity to obtain treatment as an “alternative” to arrest” belies claims that the program had a medical emphasis.²⁷⁷ Instead, “each aspect of the Search Policy was designed to assist law enforcement personnel in performing their duties.”²⁷⁸

Ferguson court documents, including memoranda, briefs,²⁷⁹ court transcripts,²⁸⁰ plaintiff exhibits,²⁸¹ joint exhibits, and the briefs' appendices²⁸² illuminate that the program's primary goal was to facilitate the arrests and criminal prosecutions of patients who used crack during their pregnancies through racially targeted drug screenings. For example, an MUSC physician testified that “although ingestion of heroin or alcohol poses serious risks of fetal harm, the nine criteria established by the taskforce members for searching pregnant women were drafted specifically to uncover cocaine use.”²⁸³ The Supreme Court found that the MUSC program violated the *Ferguson* plaintiffs'

274. Brief for Petitioners at 11, *Ferguson v. Charleston*, 532 U.S. 67 (2001) (No. 99-936).

275. *Id.* at 8.

276. *Id.*

277. *Id.* at 6. Months after the program began, drug addiction treatment was offered as an ultimatum to avoid immediate arrest. *Id.* at 8.

278. *Id.* at 4.

279. *Id.*; Brief of Respondents, *Ferguson v. Charleston*, 532 U.S. 67 (2001) (No.99-936).

280. Transcript of Oral Argument, *Ferguson v. Charleston*, 532 U.S. 67 (2001) (No. 99-936).

281. Brief for Petitioners, *supra* note 248; Brief of Respondents, *supra* note 279. “Mr. Good [MUSC's General Counsel] wrote to then Charleston County Solicitor Charles Condon to inquire as follows: I read with great interest in Saturday's newspaper accounts of our good friend, the Solicitor for the Thirteenth Judicial Circuit, prosecuting mothers who gave birth to children who tested positive for drugs . . . Please advise us if your office is anticipating future criminal action and what if anything our Medical Center needs to do to assist you in this matter.” Brief for Petitioners, *supra* note 248, at 3.

282. Brief for Petitioners, *supra* note 248, at 3 nn.4-5; Brief for APHA et al. for Petitioner, *supra* note 236.

283. Brief for Petitioners, *supra* note 248, at 11.

Fourth Amendment rights because the program authorized nonconsensual searches and seizures without a valid warrant.²⁸⁴ This ruling holds promise for future pregnant women who are tracked and arrested under similar circumstances. However, as a practical matter, such legal victories may obscure the immediate costs associated with arrests and other real challenges for pregnant women, such as: information asymmetries because pregnant women may lack notice and awareness about health care professionals' involvement with fetal protection efforts; risk of termination of parental rights after two years of incarceration, which is quite relevant as appeals may take years; pressure to accept corrosive plea deals under threat of life sentences; and inability of the most poor and vulnerable to afford knowledgeable, competent legal counsel. Moreover, what the Court did not address is that the Search Policy also represented a violation of fundamental medical ethical principles. In addition, *how* the physician-patient relationship is corrupted by doctors' and nurses' implementation of FPLs was also left unexamined.

In assessing fetal protectionism, medical personnel may—and frequently do—make wrong calls. To comply with state statutes that encroach and burden pregnant women's constitutional rights, doctors increasingly subordinate ethical obligations to their pregnant patients, while prioritizing punitive legal redress over medical treatment. It is not surprising that medical personnel are poor interpreters of state law; they are neither elected nor appointed, nor trained in the law or legislative processes. Worst of all, FPL's coercive effects and absurd outcomes impact not only pregnant women, but also the medical personnel who serve them.

C. Enlistment of Doctors to Police Pregnant Patients: Inimical to Public Health Goals

The *Burton*²⁸⁵ and *Ferguson*²⁸⁶ cases as well as Epstein's,²⁸⁷ Beltran's²⁸⁸ and Taylor's stories²⁸⁹ demonstrate the corruptibility of medical discretion and the physician-patient relationship in fetal protection cases. For pregnant women, detecting (and guarding against) the dual role of medical staff as health care providers and quasi-state criminal informants can be virtually impossible and counterintuitive, particularly as long as patients receive a modicum of medical service. Patients assume that voluntary interactions with physicians pave the path towards promoting their health and that confidentially sharing

284. *Ferguson v. Charleston*, 532 U.S. 67, 86 (2001).

285. *Burton v. Florida*, 49 So. 3d 263 (Fla. Dist. Ct. App. 2010).

286. *Ferguson v. Charleston*, 532 U.S. 67 (2001).

287. *See* Stein, *supra* note 71.

288. Eckholm, *Fetus versus Mother*, *supra* note 29.

289. Hayes, *supra* note 50.

their social and medical histories will only be used to achieve that goal.²⁹⁰ Unfortunately, fetal protection cases caution against that presumption. The cases discussed in this Article and many others chronicled through Lynn Paltrow's extensive legal advocacy and research²⁹¹ suggest that poor pregnant women trust their medical providers at a significant risk to their liberty and privacy, which is not good for society.

1. Driving Women away from Needed Medical Care

Perversely, introducing criminal sanctions and court orders for bed rest and cesarean operations may drive women away from seeking the very care that only medical staff can provide. Driving pregnant patients away from medical care is a form of punishment that harms not only women but undermines the purported state interest in nurturing fetal development. George Annas explains:

[M]arriage of the state and medicine is likely to harm more fetuses than it helps, since many women will quite reasonably avoid physicians altogether during pregnancy if failure to follow medical advice can result in . . . involuntary confinement, or criminal charges. By protecting . . . the integrity of a voluntary doctor-patient relationship, we not only promote autonomy; we also promote the well-being of the vast majority of fetuses.²⁹²

Even without the threat of law enforcement, seeking routine medical help can be embarrassing: urinating in a cup, exposing parts of one's body virtually unknown and unseen by anyone else, being prodded and poked in intimate spaces, and submitting to physically uncomfortable gynecological exams can be awkward, and disclosing intimate health secrets can be stigmatizing.²⁹³ Yet, patients surrender to these uncomfortable medical encounters, yielding their trust along with their bodies. Patients participate in this process with the expectation that their vulnerability will be afforded dignity and their

290. See, e.g., Cynthia M.A. Geppert & Laura Weiss Roberts, *Protecting Patient Confidentiality in Primary Care*, 3 SEMINARS IN MED. PRAC. 7, 7 (2000) ("Many patients assume that physician-patient confidentiality is an absolute.").

291. Paltrow & Flavin, *supra* note 4.

292. George Annas, *Protecting the Liberty of Pregnant Patients*, 316 NEW ENG. J. MED. 1213, 1214 (1987).

293. For this reason, courts have ruled various types of medical information to be protected, specifically referencing the potential for stigma, embarrassment, or humiliation: a high school student's pregnancy status, *Gruenke v. Seip*, 225 F.3d 290, 301 (3d Cir. 2000) (noting that it could be embarrassing for a high school student to reveal a pregnancy); an inmate's HIV-positive status, *Doe v. Delie*, 257 F.3d at 317, 323 (3d Cir. 2001) (holding "that the Fourteenth Amendment protects an inmate's right to medical privacy, subject to legitimate penological interests"); a government employee's medical prescription record, *Doe v. Se. Pa. Trans. Auth.*, 72 F.3d 1133, 1138 (3d Cir. 1995); a private employee's health care information sought by the government, *United States v. Westinghouse*, 638 F.2d 570, 577 (3d Cir. 1980) (carving out a privacy right that includes "results of routine testing, such as X-rays, blood tests, pulmonary function tests, hearing and visual tests."). *Id.* at 579.

communications protected.²⁹⁴ For pregnant patients, establishing and maintaining trust in their patient-physician relationship significantly influences their compliance with medical recommendations and the frequency of their prenatal visits.²⁹⁵

As discussed above, confidentiality norms in the physician-patient relationship should rival only that of the psychotherapist and her patient,²⁹⁶ lawyer and her client,²⁹⁷ or clergy and parishioners²⁹⁸ because enlisting doctors to police pregnant patients undermines not only those women's individual interests, but also broader societal goals to promote a trustworthy system of medicine that advances the public health. As one health care organization succinctly stated, "[T]he public must be assured of nonpunitive access to comprehensive care."²⁹⁹ However, law enforcement's encroachment into prenatal care is particularly counterintuitive and counterproductive to that important goal precisely because it introduces a retributive, nonempathetic framework into physician-patient interactions, which undermines the trust relationship.

For these reasons, national medical associations warn that a law enforcement approach to maternal health only "threatens to make things worse"³⁰⁰ for women and their babies. The erosion of trust is a significant

294. *Piller v. Kovarsky*, 194 N.J. Super. 392, 396 (Law Div. 1984) (noting that patients deserve "to secure medical services without fear of betrayal and unwarranted embarrassing and detrimental disclosure . . .").

295. See Vanessa B. Sheppard et al., *Providing Health Care To Low-Income Women: A Matter Of Trust*, 21 FAMILY PRACTICE 484, 484 (2004).

296. See e.g., *Jaffee v. Redmond*, 518 U.S. 1 (1996).

297. Attorney-client communications are protected from compelled disclosure under Federal Rules of Evidence. See *Swidler & Berlin*, 524 U.S. 399 (1998). The attorney-client privilege is built upon the premise that to "encourage full and frank communication between attorneys and their clients and . . . promote broader public interests in the observance of law and administration of justice" the law must provide protection for a client's communications with her attorney. See *Swidler & Berlin*, 524 U.S. 399 (1998) (holding that the attorney-client privilege does not terminate at the client's death); *Upjohn Co. v. United States*, 449 U.S. 383, 389 (1981). However, the attorney-client privilege and the duty to preserve client confidences are distinct and emanate from different sources of law. The duty of confidentiality is enforced by state law and in some jurisdictions demands a higher level of diligence in protecting client information. For example, in California, Business and Professions Code § 6068 (e)(1) mandates attorneys to "maintain inviolate the confidence, and at every peril to himself or herself to preserve the secrets, of his or her client." This rule subjects all communications and information shared during the course of the professional relationship. *Id.* The Minnesota Rules of Professional Conduct, Rule 1.6 prohibits a lawyer from knowingly "1) . . . reveal[ing] a confidence or secret of a client, 2) us[ing] a confidence or secret of a client to the disadvantage of the client, 3) us[ing] a confidence or secret of a client for the advantage of . . . a third person, unless the client consents" Limited exceptions apply permitting disclosure of client communication, such as the threat of imminent danger to a third party.

298. Ezra E.H. Griffith & John L. Young, *Clergy Counselors and Confidentiality: A Case for Scrutiny*, 32 J. AM. ACAD. PSYCHIATRY L. 43, 44 (2004) ("There is a basic societal expectation that clergy will respect the confidences of their charges.").

299. Brief for Am. Pub. Health Ass'n et al. as Amici Curiae in Support of Petitioner at 17, *Ferguson v. Charleston*, 532 U.S. 67 (2001) (No. 99-936), 2000 WL 33599645.

300. *Id.* at 14.

concern articulated by medical organizations as they understand how indispensable patient trust is to gathering sensitive information to inform a proper diagnosis and treat health care concerns.

The reality of heightened fetal protection and pressure on physicians to comply with coercive state laws urged ACOG to issue a 2011 report warning that: “Drug programs that deter women from seeking prenatal care are contrary to the welfare of the mother and fetus. Incarceration and threat of incarceration have proved to be ineffective in reducing the incidence of alcohol and drug abuse.”³⁰¹

Consistent with its observation that fetal protection laws undermine patient health, ACOG now encourages its members to work with state legislators to repeal FPL that targets pregnant substance users.³⁰²

Medical organizations are particularly concerned about the corrosive effects of law enforcement’s invasive reach into maternal health. They explain how pregnant women who suffer from drug addiction may be particularly hesitant to meet with doctors and reticent about providing details exposing the type, extent, and frequency of their drug use. Their fears concern not only their immediate pregnancies, but their children at home. Twenty years ago, a joint taskforce of the Southern Governors’ Association and the Southern Legislative Conference, which came to be known as The Southern Regional Project on Infant Mortality, released a powerful report concluding:

If pregnant women . . . feel that they will be “turned in” by health care providers or substance abuse treatment centers, they will avoid getting care. If women are able to discuss their addiction with providers without fear of retribution . . . they are more likely to enter treatment.³⁰³

Collectively, medical organizations stress that criminal law enforcement as a means of addressing substance abuse or mental health by its design is inimical to understanding that drug addiction is a disease and not a crime.³⁰⁴ Legislatures seemingly misunderstand this important medical reality, taking an approach that undermines health. The National Perinatal Association explains

301. COMMITTEE ON HEALTH CARE FOR UNDERSERVED WOMEN, AMERICAN COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS, COMM. OP. NO. 473: SUBSTANCE ABUSE REPORTING AND PREGNANCY: THE ROLE OF THE OBSTETRICIAN-GYNECOLOGIST (2011), *available at* http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Substance_Abuse_Reporting_and_Pregnancy_The_Role_of_the_Obstetrician_Gynecologist.

302. *Id.*

303. SHELLY GEHSAN, A STEP TOWARD RECOVERY: IMPROVING ACCESS TO SUBSTANCE ABUSE TREATMENT FOR PREGNANT AND PARENTING WOMEN: RESULTS FROM A REGIONAL STUDY 21 (1993); NAI HALLMAN, THE SOUTHERN REGIONAL PROJECT ON INFANT MORTALITY: A 20-YEAR RETROSPECTIVE (2005).

304. NATIONAL PERINATAL ASSOCIATION, SUBSTANCE ABUSE AMONG PREGNANT WOMEN, *available at* <http://www.nationalperinatal.org/advocacy/pdf/Substance-Abuse-in-Pregnancy.pdf> (last visited Apr. 15, 2014).

that “drug abuse is not strictly a social problem”; rather, “it is a chronic disease that impacts the brain, which makes stopping more than a matter of will power.”³⁰⁵ And while many reports highlighting the ill effects of prosecuting pregnant women concentrate on drug offenders,³⁰⁶ the premise behind their clear advocacy of restoring maternal medicine to that (and not law enforcement) should certainly extend to women prosecuted for conduct rather than drug-related fetal harm. Presumably, law enforcement intrusion into the physician-patient relationship may distract care providers, diverting or at least dividing their attention, which should be singularly focused on their patients.

2. *Decline In Trust: Undermines Health Goals and Outcomes*

Researchers associate a decline in patient trust with lower patient and provider satisfaction, increased disenrollment of care, poorer patient compliance with treatment recommendations, “and indirectly, unfavorable health status.”³⁰⁷ Researchers concerns about patient-physician trust gain added significance and urgency in low-income U.S. communities, where maternal-fetal morbidity occurs at a higher frequency than in some developing countries.³⁰⁸ The abrogation of trust in patient-physician relationships *negatively* impacts medical access and undermines the promotion of preventative care and delivery of effective perinatal services.³⁰⁹ More than likely, women will avoid doctors whom they cannot trust. And because of this fetal protection law enforcement laws’ deleterious effect extends beyond pregnant women to the fetuses they carry.³¹⁰ The American Public Health Organization emphasized in its amicus brief submitted to the U.S. Supreme Court that trust is an essential component of building “quality patient-provider relationships.”³¹¹

Despite the aggressive criminal and civil state interventions in women’s pregnancies in recent decades, statistics released in a recent World Health

305. *Id.*

306. American Medical Association, *Legal Intervention During Pregnancy*, 264 JAMA 2663, 2667 (1990); AMERICAN SOCIETY OF ADDICTION MEDICINE, BOARD OF DIRECTORS, PUBLIC POLICY STATEMENT ON CHEMICALLY DEPENDENT WOMEN AND PREGNANCY (1989), *available at* <http://www.asam.org/docs/public-policy-statements/1chemically-dep-women-9-89.pdf?sfvrsn=0>.

307. See Sheppard et al., *supra* note 295, at 484.

308. WHO, UNICEF, UNFPA, AND THE WORLD BANK, TRENDS IN MATERNAL MORTALITY: 1990 TO 2008, Annex 1. (2010), *available at* http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf.

309. Researchers explain that “providing quality prenatal and postpartum care is the primary prevention strategy to reduce maternal and infant death.” For example, simply providing access to prenatal services is not enough, effective services “include[] more than the mere existence and availability of services, it also includes quality patient-provider relationships.” See Vanessa B. Sheppard et al., *supra* note 295, at 484.

310. Brief for Am. Pub. Health Ass’n et al. as Amici Curiae in Support of Petitioner at 17, *Ferguson v. Charleston*, 532 U.S. 67 (2001) (No. 99-936), 2000 WL 33599645.

311. *Id.*

Organization (WHO) report, *Trends in Maternal Mortality: 1990 to 2008*,³¹² “place the United States fiftieth in the world for maternal mortality—with maternal mortality ratios higher than almost all European countries, as well as several countries in Asia and the Middle East.”³¹³ Although the majority of countries reduced their maternal mortality, a near double increase was reported for the United States.³¹⁴ In response to the WHO study, maternal health advocates issued a report exclaiming that the U.S. approach to maternal care is a costly, human rights failure.³¹⁵ Instead, perhaps the “overuse of medical procedures” such as cesarean surgeries, which have increased by 56 percent from 1996 to 2008 in the United States, intensify the risks of injuries to fetuses and pregnant women.³¹⁶

Ironically, U.S. maternal mortality rates were at a low in 1987 (at about 6.6 per 100,000 live births)³¹⁷ prior to the launch of hard-line legislative protectionism of fetuses that interfered in the physician-patient relationship. As the APHA recently reported, “both the WHO and the Centers for Disease Control and Prevention (CDC) vital statistics data show a substantial increase in the maternal mortality ratios over the last 2 decades.”³¹⁸ The CDC now reports U.S. maternal mortality at a rate between 12 to 15 deaths per 100,000 live births, about 3 times above the national goal.³¹⁹ Moreover, this phenomenon includes shockingly high maternal mortality rates among white women in the United States, who experience maternal mortality at a ratio of 10.5 deaths per 100,000 (a frequency higher “than the entire population of women in 31 other countries”).³²⁰

U.S. infant mortality has only marginally decreased over the past 15 years. The CDC reports that “during 2000–2005, the U.S. infant mortality rate did not decline significantly for the total population or for any racial/ethnic population.”³²¹ From 2005 to 2009, infant mortality decreased overall by about

312. WORLD HEALTH ORGANIZATION ET AL., *TRENDS IN MATERNAL MORTALITY: 1990 TO 2008* 23 (2010), available at http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf.

313. Francine Coeytaux et al., *Maternal Mortality in the United States: A Human Rights Failure*, 83 *CONTRACEPTION* 189 (2011), available at <http://www.arhp.org/UploadDocs/journaleditorialmar2011.pdf>.

314. WORLD HEALTH ORGANIZATION ET AL., *supra* note 312; Coeytaux et al., *supra* note 313.

315. Coeytaux et al., *supra* note 313, at 189 (“For a country that spends more than any other country on health care and more on childbirth-related care than any other area of hospitalization—US \$86 billion a year—this is a shockingly poor return on investment.”).

316. Coeytaux et al., *supra* note 313, at 191.

317. AM. PUBLIC HEALTH ASS’N, *REDUCING US MATERNAL MORTALITY AS A HUMAN RIGHT*, POLICY NO. 201114 (2011), available at <http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1430>.

318. *Id.*

319. *Id.*

320. *Id.*

321. CDC, *Infant Mortality Rates, by Race and Hispanic Ethnicity of Mother — United States, 2000, 2005, and 2010*, 63 *MMWR* 25 (2014), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6301a9.htm>.

7 percent to about 6.9 infant deaths per 1,000 live births. However, it remains very high among African Americans at 12.40 per 1,000 live births.³²² Notably, while improved data collection might explain the increase in reporting of maternal deaths, it does not explain the dramatic rate of maternal deaths in the United States. Medical experts explain that maternal mortality is preventable. Nevertheless, they note that rates as high as in the United States are “associated with the violation of a variety of human rights, including the mother’s right to life, the right to freedom from discrimination, and the right to health and quality health care.”³²³ What health improvements can be associated with state interventions in women’s pregnancies? Has the shifted role of health care providers produced healthier outcomes for women and babies, particularly those from low-income communities? Data such as that offered above provide compelling insights. However, more research is needed.

The protective character of law enforcement in this realm serves only to undermine and not enhance the health and well-being of pregnant women. Holding them criminally liable for the actions they undertake during pregnancy does not serve a recognized health purpose like in Powell’s case where she sought treatment for her addiction and instead suffered arrest. The urinalysis served to identify grounds to take her into custody and not to treat her addiction or to provide prenatal care.³²⁴ In Powell’s case, medical and court records reveal her consistent desire to obtain medical treatment for addiction, yet she was incarcerated instead.³²⁵

3. Shackling Further Undermines Pregnant Patients’ Health

In another case, after Lori Griffin’s arrest at her prenatal visit for distribution of cocaine to a minor, she endured three weeks “in jail in an unsanitary cell with a metal table and a cushion to serve as a bed.”³²⁶ Although police regularly brought her to the hospital for checkups, Griffin was subjected to receiving prenatal care while shackled and handcuffed,³²⁷ which is medically inadvisable because it is physically distressing and unnecessary.³²⁸

322. *Id.*

323. Comparatively, the U.S. rate of maternal mortality reveals a stunning policy failure. *See id.* The rate of maternal deaths in the United States provides an urgent example of misguided legislative action. *Id.* “It is estimated that between 1990 and 2008, 147 countries experienced a decline in maternal mortality ratio, 90 of which showed a decline of 40% or more. In two countries there was no change, and in the remaining twenty-three countries, including the United States, the maternal mortality ratio actually increased.” *Id.*

324. Brief for Petitioners at 8, *Ferguson v. Charleston*, 532 U.S. 67 (2001) (No. 99–936) (“Ms. Powell was arrested while she was still in pain and bleeding from childbirth”).

325. *Id.* at 8 n.7 (“Medical records indicate that Ms. Powell repeatedly requested help in obtaining drug treatment.”).

326. Brief for Petitioners at 7, *Ferguson v. City of Charleston*, 532 U.S. 67 (2001) (No. 99–936) (noting that “she was removed...in handcuffs and shackles to a waiting police car.”)

327. *Id.* *See also* Tessa M. Gorman, *Back on the Chain Gang: Why the Eighth Amendment and the History of Slavery Proscribe the Resurgence of Chain Gangs*, 85 CALIF. L. REV. 441, 443 (1997)

The American College of Nurse Midwives (ACNM) issued a policy statement in response to the recent trend of shackling pregnant women. The group's policy statement emphasizes, "Women should not be restrained during labor" because "[l]abor itself is a restraining condition."³²⁹ The ACNM reminds doctors that "the impairment of movement should be avoided to prevent injury and to aid the medical staff in providing care and facilitating position changes necessary for labor and birth."³³⁰ If shackling does not serve a security or medical purpose, why do states condone the practice?

States enforce shackling practices as a means of exerting retribution on its prisoners and instantiating physical and symbolic subordination.³³¹ In the case of pregnant women, shackling functionally serves an added role. That is, pregnant women civilly committed like Alicia Beltran or criminally confined like Griffin by default fit the definition of "bad mothers." For "bad mothers," shackling during labor and delivery represents a unique type of punishment, specifically linked to their misbehavior during pregnancy and inability to conform to a more perfected ideal of motherhood. Rather than being afforded dignified childbirth, which would align with purported state interests, pregnant women are subjected to particularly punitive punishment in shackling as a mechanism to humiliate and castigate. As La Donna Hopkins recalled in testimony to the Illinois legislature:

Being shackled in transport to give birth was a demoralizing, uncomfortable and frightening experience. I was at Dwight [Correctional Facility] when I went into labor. I was placed in handcuffs, had a heavy chain across my belly that my hands were attached to, along with leg irons on my ankles. I was scared to walk because of the restrictive leg irons. . . No one saw me as a woman. . . I

(noting that shackles permeate much of the American black experience—from the cruelest forms of immigration to the byproducts of Jim Crow segregation, involving chain gangs.)

328. See COMMITTEE ON HEALTH CARE FOR UNDERSERVED WOMEN, AMERICAN COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS, COMM. OP. NO. 511: HEALTH CARE FOR PREGNANT AND POSTPARTUM INCARCERATED WOMEN AND ADOLESCENT FEMALES 1, 3 (2011), available at <http://www.acog.org/~media/Committee%20Opinions/Committee%20on%20Health%20Care%20for%20Underserved%20Women/co511.pdf?dmc=1&ts=20130725T1738421657>; Ginette Gosselin Ferszt, *Giving Birth in Shackles: It's Time To Stop Restraining Pregnant Inmates During Childbirth*, 110 AM. J. NURSING 11 (2010).

329. AMERICAN COLLEGE OF NURSE-MIDWIVES, POSITION STATEMENT: SHACKLING/RESTRAINT OF PREGNANT WOMEN WHO ARE INCARCERATED (approved June 2012), available at <http://midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/00000000276/Anti-Shackling%20Position%20Statement%20June%202012.pdf>.

330. *Id.*

331. See, e.g., Priscilla A. Ocen, *Punishing Pregnancy: Race, Incarceration, and the Shackling of Pregnant Prisoners*, 100 CALIF. L. REV. 1239, 1309 (2012) (arguing that "the use of shackles on pregnant prisoners during labor and childbirth should be seen as a badge or incident of slavery").

have never committed a violent crime—I am in minimum security, but I was treated like a murderer.³³²

Similarly, Melissa Hall testified, “I was close to delivering my baby, I was in a lot of pain and I was screaming for the nurse The sheriff didn’t give me any sympathy or any privacy. He left the handcuff shackled to the bed and the leg iron shackled to the stirrup while I was delivering my baby.”³³³

Courts recognize the stigmatizing effects of shackling. For this reason, courts allow even those convicted of violent crimes the opportunity to appear in court without shackles. Writing for the majority in *Holbrook v. Flynn*, Justice Thurgood Marshall reasoned, “Shackling a defendant during court proceedings is an inherently prejudicial practice that may violate a defendant’s constitutional right to fair trial.”³³⁴ Marshall explained that the barriers to justice and a fair trial included jurors’ perceptions about *what* is represented by shackling. Pregnancy by extension deserves similar protection from the prejudicial effects shackling can render in the pregnancy contexts. From pregnant women’s experiences with guards to health care professionals and other hospital staff and clients, shackling imposes a stigma of poor motherhood that may lead to subpar medical treatment.

Shackling pregnant women during labor and delivery further illustrates misguided public policy in reproductive health care. These powerful accounts of shackling also expose the externalities that emerge from statutory interventions in women’s pregnancies. Not all women arrested or detained for violating fetal protection will suffer this fate. However, for many pregnant women subjected to law enforcement interventions in their pregnancies, shackling is a default state mechanism.

For Beltran, a routine medical appointment disturbingly resulted in her being handcuffed and shackled, pleading for release from state-imposed civil confinement to protect her fetus.³³⁵ Likewise, had Griffin not been reported to law enforcement by her health care providers for drug addiction, she likely would have given birth without the further imprisonment by shackles that risked her health as well as the fetus during delivery. Nor are these accounts selective or isolated incidences. Because about 5–6 percent of women who enter prison are pregnant, over 6,600 will give birth during incarceration. A significant percentage of those women will be subjected to the denigrating and

332. See INTERNATIONAL HUMAN RIGHTS CLINIC ET AL., THE SHACKLING OF INCARCERATED PREGNANT WOMEN: A HUMAN RIGHTS VIOLATION COMMITTED REGULARLY IN THE UNITED STATES 5 (2013) (quoting LaDonna Hopkins) [on file with author].

333. *Id.* at 4.

334. *Holbrook v. Flynn*, 475 U.S. 560, 571 (1986).

335. Eckholm, Fetus versus Mother, *supra* note 29. See also Daniella Silva, *Shackled and Pregnant: Wis. Case Challenges ‘Fetal Protection’ Law*, NBC News (Oct. 24, 2013), <http://usnews.nbcnews.com/news/2013/10/24/21117142-shackled-and-pregnant-wis-case-challenges-fetal-protection-law?lite> (reporting that “what started as a routine visit ended with Beltran eventually handcuffed and shackled in government custody”).

medically dangerous experience of being shackled during labor or labor and birth, making this an important issue for legal and human rights discourse.³³⁶ Despite federal law prohibiting shackling of pregnant women in federal prisons, states remain slow to follow this example.³³⁷ According to one study, thirty-two states have not enacted anti-shackling legislation to protect women during pregnancy.³³⁸

Shackling is also psychologically damaging, particularly for African American women because of the iron chain's cruel and unremitting use during slavery. Professor Priscilla Ocen advances this perspective, explaining that shackling "attaches to Black women in particular through the historical devaluation, regulation, and punishment of their exercise of reproductive capacity in three contexts: slavery, convict leasing, and chain gangs in the South."³³⁹ Shackling pregnant women—a common feature of law enforcement in some states—has many negative connotations and brings to mind the shameful subordination of and discrimination against an entire class of persons during slavery.³⁴⁰

The important state interest in promoting and safeguarding public health is not furthered by law enforcement's intrusion in health care delivery.³⁴¹ Yet, application of the criminal frame in medicine, particularly maternal health, risks corroding an already delicate system. Legislatures' protective intuitions in pregnancy may prove fateful and dissuade pregnant women from seeking vital prenatal care.³⁴² If hospitals and clinics become symbolically aligned with criminal justice and metaphorically associated with police precincts and jails, women may put off receiving crucial prenatal services.

There are other reasons for rethinking the state's enlistment of doctors as quasi-criminal agents, namely quality of care and promotion of healthy outcomes for pregnant women and fetuses. In its amicus brief to the Supreme Court in *Ferguson* the APHA emphasized that if providers have a clear understanding of their patients' drug addiction, "they can focus on providing interventions that substantially improve health outcomes for pregnant women

336. See INTERNATIONAL HUMAN RIGHTS CLINIC ET AL., THE SHACKLING OF INCARCERATED PREGNANT WOMEN: A HUMAN RIGHTS VIOLATION COMMITTED REGULARLY IN THE UNITED STATES 4–6 (2013).

337. *Id.*

338. *Id.* at 1. Neither are the justifications for shackling pregnant women persuasive. In the states that abolished the practice, neither violence due to lack of restraint nor mass escape attempts are indicated. *Id.* at 6–7.

339. Priscilla A. Ocen, *Punishing Pregnancy: Race, Incarceration, and the Shackling of Pregnant Prisoners*, 100 CALIF. L. REV. 1239, 1309 (2012).

340. *Id.*

341. Brief for Am. Pub. Health Ass'n et al. as Amici Curiae in Support of Petitioner, *Ferguson v. Charleston*, 532 U.S. 67 (2001) (No. 99-936), 2000 WL 33599645.

342. *Id.* at 13 ("Numerous studies have confirmed that the intrusion of the criminal justice system on health care practices aggravates exponentially the already-strong reluctance to seek medical attention and treatment.").

and for children.”³⁴³ They report that women are more likely to “complete drug treatment, and far more likely [to avail themselves of] early, comprehensive prenatal care.”³⁴⁴ And even women who cannot access treatment or who simply struggle with addiction throughout pregnancy can have improved fetal health outcomes with prenatal care. According to the APHA, “[P]regnant women who use cocaine but who have at least four prenatal care visits have been found to face significantly reduced chances of delivering low birth weight babies.”³⁴⁵

III.

THE EQUAL PROTECTION CONUNDRUM

In Parts I and II, this Article analyzed the imperfections of contemporary state interventions to protect fetal health. As discussed, state intrusions in pregnancies impose conflicting duties on physicians, requiring that they serve at one turn as vigilant gatekeepers of patient secrets and at another as interlopers and government informants. These methods to address fetal health—state-imposed bed rest, compulsory cesarean surgeries, prosecutions for failed suicide, and civil confinement to protect fetuses—create official hierarchies, ranking the legal and health interests of fetuses above those of pregnant patients.³⁴⁶

Part III advances normative equal protection arguments in response to punitive state interventions in women’s pregnancies.³⁴⁷ It considers whether

343. *Id.* at 17.

344. *Id.* (citing STEPHEN R. KANDALL, *SUBSTANCE AND SHADOW: WOMEN AND ADDICTION IN THE UNITED STATES* 278, 279 (1996)).

345. *Id.*

346. Eckholm, *Fetus versus Mother*, *supra* note 29, at A1. Moreover, such laws distinguish even between fetuses as some are afforded greater state intervention than others.

347. Fetal protection laws could be challenged as violations of substantive due process, also protected by the Fourteenth Amendment. “[N]or shall any State deprive any person of life, liberty, or property, without due process of law . . .” U.S. Const. amend. XIV, § 1. This Article does not take up that constitutional analysis beyond that identified in Parts I and II as those issues are addressed in a forthcoming project, *The Drug War’s Forgotten Casualties: Women, Children and The Destruction of Family*, which also considers the primacy of Eighth Amendment considerations in protecting pregnant women from the cruel and unusual reach of the state into their pregnancies. (Unpublished on file with author). For a discussion of substantive due process analyses in reproductive health scholarship in recent years, see Annette Ruth Appell, *Accommodating Childhood*, 19 *CARDOZO J.L. & GENDER* 715, 752 (2013) (critiquing the Fourteenth Amendment as affording “negative-only rights against state-sponsored discrimination or interference with fundamental liberty, including exercise of religious, familial, and sexual freedom”); Andrew Coan, *Assisted Reproductive Equality: An Institutional Analysis*, 60 *CASE W. RES. L. REV.* 1143 (2010) (applying a comparative institutional analysis approach to assisted reproduction); Ariela R. Dubler, *Sexing Skinner: History and The Politics of the Right To Marry*, 110 *COLUM. L. REV.* 1348 (2010) (arguing that *Skinner v. Oklahoma* emerged from a political moment reflected in ongoing conversations about the relationship between sexual freedom, procreation and marriage); Melanie Jacobs, *Intentional Parenthood’s Influence: Rethinking Procreative Autonomy and Federal Paternity Establishment Policy*, 20 *AM. U. J. GENDER, SOC. POL’Y & L.* 489, 490 (2012) (challenging “why a man who has no intent or desire to be a father should be adjudicated a legal father - with subsequent legal responsibilities”); Jennifer M. Keighley, *Physician Speech and Mandatory Ultrasound Laws: The First Amendment’s Limit on Compelled Ideological*

such legislative efforts, despite burdening women's medical and reproductive liberties, pass constitutional muster. This Part considers whether FPLs conflict with Fourteenth Amendment values.³⁴⁸ Taken as an empirical question, it considers whether fetal protection efforts arbitrarily focus on some classes of pregnant women and certain types of potentially dangerous conduct to the exclusion of others. And if so, can that level of selective state punishment without medical and legal justification withstand constitutional challenge?

A. The Empirical Problem

The legitimacy of fetal protection laws rests on an explicit welfare assumption rooted in public health rationales. The laws are based on the assumption that state interventions in pregnancies promote the health of fertilized embryos and fetuses.³⁴⁹ Much of this thinking presumes a life and rights for embryos and fetuses apart and distinct from that of pregnant women who bear them. However, as shown throughout this Article, neither fetal nor maternal health outcomes are necessarily improved by punitive state interventions in women's pregnancies. In fact, according to medical organizations, fetal protection efforts may result in worse health outcomes for pregnant women and their fetuses.³⁵⁰

Empirical studies reveal that in the years since the aggressive involvement of states in women's pregnancies, maternal mortality nearly doubled and only slight decreases in fetal mortality were observed.³⁵¹ Despite the intuitive pull

Speech, 34 CARDOZO L. REV. 2347 (2013) (asserting that state laws mandating physicians to carry out state's ideological agendas such as ultrasound exams compel speech); Reva B. Siegel, *Roe's Roots: The Women's Rights Claims That Engendered Roe*, 90 B.U. L. REV. 1875 (2010) (examining the understandings and conceptual frameworks "animating feminist abortion rights claims in the years before *Roe v. Wade*"); Laura Sjoberg, *Where Are the Grounds For the Legality of Abortion? A 13th Amendment Argument*, 17 CARDOZO J.L. & GENDER 527, 541 (suggesting that the basis for abortion rights are best framed in the Thirteenth Amendment contexts because, "[m]ore imagined than real in life, sex equality in law tends to be more formal or hypothetical than substantive and delivered"); and Julie Suk, *From Antidiscrimination to Equality: Stereotypes and the Life Cycle in the United States and Europe*, 60 AM. J. COMP. L. 75, 84 (2012) (applying a substantive due process analysis to mandatory maternity leave and explaining that "mandatory maternity leave exemplifies the paradigmatic violation of the equal protection-substantive due process synthesis that many scholars have identified as U.S. antidiscrimination doctrine").

348. The Fourteenth Amendment guarantees that "[n]o State shall make or enforce any law which shall . . . deny to any person within its jurisdiction the equal protection of the laws." U.S. CONST. amend. XIV, § 1.

349. It may be further assumed that the interventions are the least constitutionally burdensome means of promoting that interest. As with any government legislation, there is an underlying presumption of fairness and equity and that laws are not arbitrarily applied in the name of health nor selectively enforced.

350. Brief for APHA et al. for Petitioner, *supra* note 236, at 13.

351. The United States ranks fiftieth among nations reporting maternal morbidity to the World Health Organization. The rate of maternal death has doubled since 1987, while other nations' rates of maternal morbidity declined during the same period. There is no explicit correlation between maternal and fetal mortality and fetal protection interventions. However, the data provides a broader view of maternal health at a time when states have enacted interventionists' strategies in the name of

that fetal health benefits derive from punitive state intervention in women's pregnancies, the empirical literature on maternal-fetal health suggests otherwise.³⁵² When states introduce punitive norms into child bearing that include interfering with the physician-patient relationship and threats of arrests and incarceration, women may forego care. Furthermore, there are no guarantees that women who come under the supervision of the state necessarily give birth in a hospital or under dignified circumstances. Babies are sometimes born in prison under exceedingly unsanitary conditions.³⁵³ Therefore, states' efforts to concentrate criminal attention on maternal conduct as a means to promote fetal health are destined to fail not only on moral but also on medical efficacy grounds.

1. Abstracted Legal and Medical Framing

Fetal health is a complex and nuanced issue. In Professor Reva Siegel's meticulously detailed historical account of abortion regulation,³⁵⁴ she observed that legal examination of fetal protectionist legislation was abstracted from the social context. Indeed, fetal protection regulation is also abstracted from the medical context. Siegel attributed this ingrained abstraction to nineteenth century anti-abortion and contraception movements in the United States, which "presented the fetus as an object of public interest, scarcely connected physically or socially to the woman bearing it."³⁵⁵ And when an embryo or fetus becomes the concern of regulation conspicuously apart from the pregnant woman gestating it, Siegel warns that "it becomes possible to reason about regulating women's conduct without seeming to reason about women at all."³⁵⁶

promoting health. WORLD HEALTH ORGANIZATION ET AL., TRENDS IN MATERNAL MORTALITY: 1990 TO 2008, 23, Annex 1 (2010), available at http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf.

WHO, UNICEF, UNFPA AND THE WORLD BANK, TRENDS IN MATERNAL MORTALITY: 1990 TO 2010, ANNEX 1, (2012), available at https://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf.

352. Brief for APHA et al. for Petitioner, *supra* note 236, at 13.

353. Bekah Porter, *Dubuquer Gives Birth Alone In Jail Cell*, TELEGRAPH HERALD, May 15, 2009, http://www.thonline.com/news/feature_stories/article_c527db84-db00-514e-ab65-a7615e5490f4.html (describing Tara Keil's unsettling birth in a toilet after minutes of screaming for help and being offered food rather than a nurse or doctor). Similarly, Ambrett Spencer suffered the distressing effects of birthing while in prison. Her baby died after hours that she pleaded for help. See John Dickerson, *Arpaio's Jail Staff Cost Ambrett Spencer Her Baby, and She's Not the Only One*, PHOENIX NEW TIMES, Oct. 30, 2008, <http://www.phoenixnewtimes.com/2008-10-30/news/arpaio-s-jail-staff-cost-ambrett-spencer-her-baby-and-she-s-not-the-only-one/>. Shawanna Nelson was forced to endure labor while shackled, guards finally relented for the actual delivery, but immediately shackled her right after her child's birth. Adam Liptak, *Prisons Often Shackle Pregnant Inmates in Labor*, N.Y. TIMES, Mar. 2, 2006, <http://www.nytimes.com/2006/03/02/national/02shackles.html>.

354. Reva Siegel, *Reasoning From The Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection* 44 STAN. L. REV. 261 (1992).

355. *Id.* at 333.

356. *Id.* at 333.

When legal analysis situates fetuses as independent and distinct from pregnant women, proponents of FPLs can easily establish tailored medical narratives about fertilized eggs, embryos, and fetuses, including their potential futures quite separate and apart from pregnant women's physical, psychological, and physiological selves. Often, these narratives lack empirical rigor, thus leading to arbitrary designations regarding what should be reregulated conduct and what is exempt. Race and class biases creep into arbitrary intervention.³⁵⁷ It becomes easier to ignore the social and economic conditions that dominate pregnant women's lives, including employment, marital status, education, and poverty. It also becomes easier to rationalize and analyze fetal harms similar to child harms, despite their logical and legal dissimilarities.³⁵⁸

Dietrich v. Northampton is instructive on this point. In 1884, Justice Oliver Wendell Holmes ruled that it would be far too remote if an action could be maintained on behalf of a fetus still dependent on the pregnant woman bearing it. Justice Holmes reasoned that any argument which suggested that a fetus "stands on the same footing as . . . an existing person" is hindered and not helped by the fact that a fetus does not have even a "quasi independent life."³⁵⁹ In dicta, the court maintained that if a pregnant woman could not recover from the injury sustained by the fetus, neither would it be legally sound for the fetus to recover.³⁶⁰ Contemporary fetal protection regulation presents similar medical and legal concerns regarding remoteness.

357. Figidor & Kaeser, *supra* note 6, at 4 (noting stark racial disparities in pregnant patients' arrests).

358. Interestingly, these narrative constructions of the independent fetus emerged only in the last half of the century, and significantly, in the past thirty years as a focused component of the nation's drug war. For six decades, *Dietrich v. Northampton* represented juridical thinking on the issue of fetal rights and personhood. The Massachusetts Supreme Court ruled that a fetus of four or five months, that survived a negligently induced miscarriage for possibly ten to fifteen minutes did not meet the legal standard of a "person." Thus, the mother could not recover under the wrongful death statute enacted in Massachusetts. *Dietrich v. Northampton*, 138 Mass. 14, 17 (1884) (in denying the claim, the court noted, the fetus "was a part of the mother at the time of the injury."). *See also* Stallman v. Youngquist, 531 N.E.2d 335 (Ill. 1988) (denying recovery against a mother for unintentional injuries sustained in utero to a child born alive). Until 1946, all American jurisdictions followed *Dietrich's* ruling that the common law did not recognize a cause on behalf of a fetus. *See* Kathryn S. Banashek, *Maternal Prenatal Negligence Does Not Give Rise to a Cause of Action*, Stallman v. Youngquist, 125 Ill. 2d 267, 531 N.E.2d 335 (1988), 68 WASH. U. L.Q. 189, 190 (1990) (noting that "[h]istorically, courts denied a fetus recovery against any defendant for the negligent infliction of prenatal injuries on the ground that a mother and fetus comprised a single legal entity").

359. *Dietrich*, 138 Mass. at 16. For over sixty years, this opinion served as the basis for common law jurisprudence regarding the legal standing of a fetus. Courts consistently ruled that a fetus had no legal status apart from the pregnant woman bearing it. *See* Bonbrest v. Kotz, 65 F. Supp. 138 (D.D.C. 1946); Stallman, 531 N.E.2d at 357.

360. *Dietrich*, 138 Mass. at 17.

2. *The Multi-Headed Hydra: Environment and Poverty*

Many different factors influence states' chief concerns about fetal birth weight and long term health beyond maternal conduct and control, such as secondhand smoke inhaled by the mother, her environment, and her exposure to domestic violence,³⁶¹ poverty,³⁶² pesticides,³⁶³ carcinogens,³⁶⁴ and lead.³⁶⁵ Sometimes, these factors perniciously combine in relentless cycles; poor women suffering the dire hardships of poverty are more likely to be exposed to lead in their homes, inhale pesticides intended to control pest infestations, and live near toxic waste facilities³⁶⁶ due to housing stratification, proximity to a military base, or the affordability of hazard-intense neighborhoods.³⁶⁷

361. Jacquelyn C. Campbell, *Health Consequences of Intimate Partner Violence*, 359 LANCET 1331, 1331–36 (2002); see also Julie A. Gazmararian et al., *Prevalence of Violence Against Pregnant Women: A Review of the Literature*, 275 JAMA 1915, 1915–20 (1996).

362. In their relatively recent study, researchers at the University of Pennsylvania found that African American women are three times more likely to suffer death in pregnancy than their white counterparts. Tanya Nagahawatte & Robert Goldenberg, *Poverty, Maternal Health, and Adverse Pregnancy Outcomes*, 1136 ANNALS N.Y. ACAD. SCI. 80, 81 (2008). Their research also confirmed that African American women are two times more likely to experience a premature birth. *Id.* And, African American women may be up to four times more likely to suffer a “very early” preterm delivery than all other ethnic groups. *Id.* The researchers attributed possible lower prenatal visits among poor women to the “inability to pay for otherwise available services, and failure to seek services, because of prior negative experiences.” *Id.* (explaining that receiving “culturally inappropriate and unsatisfying services, reproach and sanctions for poor health habits may contribute to fewer prenatal visits among low-income women”).

363. See ELIZABETH HARRISON ET AL., JOHNS HOPKINS WOMEN'S & CHILDREN'S HEALTH POL'Y CTR., ENVIRONMENTAL TOXICANTS AND MATERNAL AND CHILD HEALTH: AN EMERGING PUBLIC HEALTH CHALLENGE 1, 2 (2009), available at http://www.jhsph.edu/research/centers-and-institutes/womens-and-childrens-health-policy-center/publications/Environ_Tox_MCH.pdf (“Air pollutants and pesticides also are linked to poor pregnancy outcomes [. . .] PCBs and DDT, increases the risk of preterm birth, low birth weight, and miscarriage.”).

364. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO/RCED-83-168, SITING OF HAZARDOUS WASTE LANDFILLS AND THEIR CORRELATION WITH RACIAL AND ECONOMIC STATUS OF SURROUNDING COMMUNITIES (1983), available at <http://archive.gao.gov/d48t13/121648.pdf>; HARRISON ET AL., *supra* note 363.

365. Lead exposure through inhalation or consumption can result from lead paint contaminated soil and dust. The effects include a risk of miscarriage and still birth, as well as preterm birth, low birth weight, and neuro developmental effects. See HARRISON ET AL., *supra* note 363; Claire B. Ernhart et al., *Intrauterine Exposure to Low Levels of Lead: The Status of the Neonate*, 41 ARCHIVES ENVTL. HEALTH 287 (1986); Tom Greene & Claire B. Ernhart, *Prenatal and Preschool Age Lead Exposure: Relationship with Size*, 13 NEUROTOXICOLOGY & TERATOLOGY 417 (1991).

366. Since the 1980s, a series of environmental studies revealed private industries as well as local, state, and federal governments were systematically placing chemical plants, oil refineries, garbage dumps, and other hazardous waste sites in poor and African American communities. A *New York Times* journalist noted that in some of the worst hit communities, “[T]he air can be thick enough to make you gag, and you find that the rates of cancer, heart disease, stroke and the like are off the charts.” Bob Herbert, *Poor Black and Dumped On*, N.Y. TIMES, Oct. 5, 2006, http://www.nytimes.com/2006/10/05/opinion/05herbert.html?_r=0 (warning that the environmental impacts on African American health, what he refers to as “the carnage — the terrible illnesses and the premature deaths — is hidden”). Some of these states are the very ones where African American women have been prosecuted. See Edward Patrick Boyle, *It's Not Easy Bein' Green: The Psychology of Racism, Environmental Discrimination, and the Argument for Modernizing Equal Protection*

The Government Accountability Office's (GAO) report on the correlation between hazardous waste dumping and racial and economic status further underscores the tragic circumstances in which low-income women of color live.³⁶⁸ These are not narratives of intent, which frame so much of legislative accounts about pregnant women's conduct toward fetuses. In their study involving two thousand women, the California Birth Defect Monitoring Program found that women who lived within one-fourth mile of a hazardous waste site were twice as likely to birth babies with neural tube disabilities and four times as likely to birth children with serious heart conditions.³⁶⁹ It would

Analysis, 46 VAND. L. REV. 937, 967 (1993) (noting "nationwide phenomenon that minority neighborhoods bear a disproportionately large environmental burden compared to whites"); Rachel D. Godsil, *Remediating Environmental Racism*, 90 MICH. L. REV. 394, 397 (1991); Marianne Lavelle & Marcia Coyle, *The Federal Government, in its Cleanup of Hazardous Sites and its Pursuit of Polluters, Favors White Communities Over Minority Communities Under Environmental Laws Meant to Provide Equal Protection for All Citizens, A National Law Journal Investigation Has Found*, 15 NAT'L L.J., Sept. 21, 1992, at S2; Gerald Torres, *Race, Class, and Environmental Regulation*, 63 U. COLO. L. REV. 839 (1992); Keith Schneider, *Minorities Join to Fight Polluting Neighborhoods*, N.Y. TIMES, Oct. 25, 1991, at A20; Roberto Suro, *Pollution-Weary Minorities Try Civil Rights Tack*, N.Y. TIMES, Jan. 11, 1993, at A1.

The largest hazardous waste landfill in the United States is located in Emelle, Alabama a part of Sumter County, a community where 90 percent of the population is African American. Of the overall county, African Americans comprise 70 percent. Herbert, *supra* note 366; Curt Davidson, *Emelle, Alabama: Home of the Nation's Largest Hazardous Waste Landfill* (last visited Apr. 16, 2015), <http://www.umich.edu/~snre492/Jones/emelle.htm>. In this Alabama community, residents absorb hazardous waste from forty-eight states and some foreign nations. Curt Davidson, *Emelle, Alabama: Home of the Nation's Largest Hazardous Waste Landfill* (last visited Apr. 16, 2015), <http://www.umich.edu/~snre492/Jones/emelle.htm>; Herbert, *supra* note 366. The disparities associated with where hazards are dumped and what communities are left to suffer the consequences is a devastating consequence of poverty and racism. See U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 364; Michael P. Healy, *The Preemption of State Hazardous and Solid Waste Regulations: The Dormant Commerce Clause Awakens Once More*, 43 WASH. U. J. URB. & CONTEMP. L. 177, 179 (1993) (critiquing the Supreme Court's interpretation of the commerce clause to apply to the disposal of waste across state lines, which constrains states from imposing higher fees for out of state waste imported into the state); Richard Lazarus, *Pursuing Environmental Justice: The Distributional Effects of Environmental Justice*, 87 NW. U. L. REV. 787, 790 (1993) (noting that environmental justice has been relatively under-explored by lawyers).

367. See, e.g., Jane Kay & Cheryl Katz, *Pollution, Poverty, People of Color: The Factory on the Hill*, ENVTL. HEALTH NEWS, June 4, 2012 (noting that low-income residents living near hazardous sites may find affordable homes and "save money on shelter, but they pay the price in health"), available at <http://www.environmentalhealthnews.org/ehs/news/2012/pollution-poverty-and-people-of-color-richmond-day-1>.

368. In a study based on census data from 1980, the GAO examined four hazard sites in the U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 364. They reported that with three of the four sites: Chemical Waste Management, Industrial Chemical Company, and the Warren County PCB Landfill, "the majority of the population [. . .] where the landfills are located is Black." *Id.* The GAO also noted that at each of the four sites, the African American population had a lower mean income than the mean income of all other racial and ethnic populations within those towns, and represented the majority of those living below poverty for families of four. The mean income for a family in poverty was roughly \$7,400 per year. *Id.* The income of the African Americans living near hazardous waste was lower than even the nation's poverty level. GOV'T ACCOUNTABILITY OFFICE, *supra* note 364.

369. CALIFORNIA BIRTH DEFECTS MONITORING PROGRAM, BIRTH DEFECTS AND HAZARDOUS WASTE SITES (1999), available at <http://www.cdph.ca.gov/programs/CBDMP/>

be absurd to attach punitive reproductive standards to these women's pregnancies in the name of promoting fetal health.³⁷⁰

Fetal protection efforts largely ignore many of the intractable socio-economic conditions experienced by low-income pregnant women. Though these conditions could also motivate state action on behalf of fetuses, states choose not to impose constraints on industries, manufacturers, municipalities, or states to reduce the environmental factors that may cause fetal harm. Dr. Hallum Hurt's decades of research on the factors that cause poor academic performance, stress, and violence concludes that "poverty is a more powerful influence on the outcome of inner-city children than gestational exposure to cocaine."³⁷¹

3. The "Crack Baby" Myth

Dr. Hurt's research, following 110 children exposed to crack in utero, showed virtually no difference between these children and the control group. The violence and stress associated with their environments, however, proved quite profound:

81 percent of the children had seen someone arrested; 74 percent had heard gunshots; 35 percent had seen someone get shot; and 19 percent had seen a dead body outside—and the kids were only 7 years old at the time. Those children who reported a high exposure to violence were likelier to show signs of depression and anxiety and to have lower self-esteem.³⁷²

Early iterations of fetal protection efforts primarily concerned fetal exposure to crack based on media consensus that the drug caused severe damage to fetuses.³⁷³ The media pounced on a preliminary study conducted by

Documents/MO-CBDMP-HazWasteSites.pdf. See also JEAN D. BRENDER & JOHN S. GRIESENBECK, TEX. A&M SCH. RURAL PUB. HEALTH, HAZARDOUS WASTE SITES, INDUSTRIAL FACILITIES, AND ADVERSE PREGNANCY OUTCOMES IN DALLAS, DENTON, AND TARRANT COUNTIES, 1997–2000 1 (2008) (noting that prior studies find "an association between living near hazardous waste sites and all congenital malformations combined [with], chromosomal anomalies, neural tube and heart/circulatory defects), available at <http://dc234.4shared.com/doc/eBvYQoIn/preview.html>. In this study, the authors found, women who birthed babies with isolated oral clefts were 5.7 times more likely than control group mothers to live within one mile of a hazardous waste site. Mothers of babies experiencing Down syndrome were also more likely to live within one mile of a hazardous waste site than the control group mothers. *Id.* at 6. Close proximity to hazardous waste was also associated with spina bifida and anencephaly. *Id.* The authors also noted characteristics among the women who lived in closer proximity to hazardous waste sites: they were more often Latina and with modest education. *Id.* at 8.

370. The conditions of abject poverty compound and may be difficult to extricate; *what legislators perceive as the results of maternal harms may also be caused by environmental conditions associated with indigence and destitution.*

371. Susan FitzGerald, 'Crack Baby' Study Ends With Unexpected But Clear Result, PHILA. INQUIRER, July 22, 2013, http://articles.philly.com/2013-07-22/news/40709969_1_hallam-hurt-so-called-crack-babies-funded-study.

372. *Id.*

373. Katharine Greider, *Crackpot Ideas*, MOTHER JONES, July/August 1995, <http://www.motherjones.com/politics/1995/07/crackpot-ideas> (depicting how "local news organs spun

a young doctor at Northwestern Memorial Hospital, Dr. Ira Chasnoff, whose research involved only twenty-three babies and no control group.³⁷⁴ Within three days of the study's release, media frenzy began.³⁷⁵ In interviews Chasnoff explained that his findings indicated crack has "just as devastating effect[s] on pregnancy and the newborn as heroin."³⁷⁶ Chasnoff warned that crack caused some babies to be born brain damaged and that some were overwhelmed by eye contact with their mothers.³⁷⁷ According to Chasnoff, the babies exhibited tremulous symptoms and others claimed the babies were too difficult to hold because they cried and flailed their arms. Hysteria followed Chasnoff's preliminary research, which earned him notoriety, but which should not have been generalized.

Chasnoff's paper as well as his imprudent pronouncements in interviews contributed to a powerful national narrative about crack threatening to unleash its progeny on a country ill-prepared for such devastation.³⁷⁸ Speculations describing the children as abnormal and predicting their inability "to enter classic school room[s] and function in large groups of children"³⁷⁹ stoked national concern. In media accounts, pundits and legislators distinguished crack from cocaine, claiming that crack posed a far more serious threat and "to many more young children" than powder cocaine, because "mothers use" crack.³⁸⁰

their own versions of the crack-baby story, taking for granted the accuracy of its premise . . . Reporters went into hospital nurseries and special schools and borrowed the images of premature babies or bawling African-American preschoolers to illustrate their crack-baby stories"); Michael Winerip, *Revisiting the 'Crack Babies' Epidemic*, *supra* note 121; David C. Lewis et al., *Top Medical Doctors and Scientists Urge Major Media Outlets to Stop Perpetuating "Crack Baby" Myth*, NAT'L ADVOCES. FOR PREGNANT WOMEN (Feb. 25, 2004), <http://www.advocatesforpregnantwomen.org/articles/crackbabyltr.htm>.

374. Ira J. Chasnoff et al., *Cocaine Use in Pregnancy*, 313 NEW ENG. J. MED. 666 (1985); *Crack Babies: A Tale From The Drug Wars: Retro Report* [hereinafter *Retro Report*], (N.Y. Times May 20, 2013), available at <http://nyti.ms/116qYmh> (video documenting multiple interviews with Dr. Chasnoff in the 1980s).

375. *Crack Babies: A Tale From The Drug Wars: Retro Report* (N.Y. Times May 20, 2013), available at <http://nyti.ms/116qYmh>.

376. *Id.*

377. *Id.*

378. Susan Chira, *Children of Crack: Are the Schools Ready? A Special Report: Crack Babies Turn 5 and Schools Brace*, N.Y. TIMES, May 25, 1990, at A1.

379. *Retro Report*, *supra* note 374.

380. In 1986, Congress acted on the widely embraced assumption that crack posed a more significant threat to its users and society by enacting a measure that came to be known as the "100-to-1 drug ratio." Douglas J. Besharov, *Crack Babies: The Worst Threat is Mom Herself*, WASH. POST, Aug. 6, 1989, available at http://www.welfareacademy.org/pubs/childwelfare/crackbabies_89_0806.pdf. At the time, members of Congress and some within the medical community believed crack to be a more potent and powerful form of a cocaine derivative. *See id.*

Legislators also believed that crack concentrated the potency of cocaine, and drug sentencing laws came to reflect this perception so that "a person convicted of selling five grams of crack—about the weight of a teaspoon of salt—triggers the same five-year mandatory minimum sentence as a person convicted of selling 500 grams of powder cocaine, roughly the weight of a loaf of bread." *See* Theo Emery, *Will Crack-Cocaine Sentencing Reform Help Current Cons*, TIME MAG., Aug. 7, 2009, available at <http://content.time.com/time/nation/article/0,8599,1915131,00.html>.

Legislators assumed that crack and the pregnant women addicted to the drug caused a medical scourge on African American fetuses, and potentially the nation. Politicians expected these babies to require sophisticated medical treatments and, eventually, special needs services at public schools.³⁸¹ One politician claimed that crack babies would be “the most expensive babies ever born in America” and that they were “going to overwhelm every social service” program that they would encounter until their deaths.³⁸² President Ronald Reagan held a national press conference with the First Lady, Mrs. Nancy Reagan, to warn Americans about the crack scourge.³⁸³ Prominent individuals echoed these prophecies, firmly entrenching the crack baby myth. For example, John Silber, then the president of Boston University, lamented, “crack babies [] won’t ever achieve the intellectual development to have consciousness of God.”³⁸⁴ At the time, many legislators, prosecutors, and policy analysts shared the view that crack severely harmed fetuses, causing tens of thousands of infants to be born afflicted with disabilities and learning impairments.³⁸⁵

Careful researchers whose studies offered more nuanced accounts about intrauterine exposure to crack found themselves shut out of the mainstream discourse. Charles Krauthammer’s *Philadelphia Inquirer* article, “Worse Than ‘Brave New World’: Newborns Permanently Damaged By Cocaine”³⁸⁶ reflects the tone of news media investigating crack babies. Krauthammer, a Pulitzer Prize-winning journalist, warned readers that the “newest horror” was being born in American inner cities.³⁸⁷ That horror, “a bio-underclass, a generation of physically damaged cocaine babies whose biological inferiority is stamped at birth,” lurked among Americans in poor neighborhoods, born to black

381. Priscilla Van Tassel, *Schools Trying to Cope With ‘Crack Babies,’* N.Y. TIMES, Jan. 5, 1992, <http://www.nytimes.com/1992/01/05/nyregion/schools-trying-to-cope-with-crack-babies.html?src=pm&pagewanted=2>.

382. *Retro Report*, *supra* note 374 (quoting Representative George Miller).

383. Ronald Reagan, President, ‘Just Say No’—Address To The Nation (Sept. 14, 1986) (available at <http://www.cnn.com/SPECIALS/2004/reagan/stories/speech.archive/just.say.no.html>).

384. Greider, *supra* note 373 (quoting Silber); Nancy Reagan, First Lady, ‘Just Say No’—Address To The Nation (Sept. 14, 1986) (warning that no one was safe from the crack epidemic, recounting a baby who had multiple strokes at only days old) (available at <http://www.cnn.com/SPECIALS/2004/reagan/stories/speech.archive/just.say.no.html>). *See also* Cheryl Sullivan, *US Health-Care Crisis in the Making: Staggering Numbers of Drug-Addicted Infants Strain Facilities*, CHRISTIAN SCI. MONITOR, Feb. 15, 1989, <http://www.csmonitor.com/1989/0215/acrack.html>.

385. Besharov, *supra* note 380. Crack became a matter of soundbites for political campaigns. In a typical example of inflamed punditry, William Weld, the former Governor of Massachusetts appealed to that state’s voters in a heated U.S. Senate race using that rhetoric: “[a]t the same time working people are struggling to make ends meet, John Kerry wants to give their tax dollars to crack addicts.” Timothy J. Connolly, *Kerry and Weld Keep Pressure On*, WORCESTER TELEGRAM & GAZETTE, Sept. 18, 1996, at A2.

386. Charles Krauthammer, *Worse Than ‘Brave New World’: Newborns Permanently Damaged by Cocaine*, PHILA. INQUIRER, Aug. 1, 1989, http://articles.philly.com/1989-08-01/news/26148256_1_cocaine-babies-crack-babies-damage.

387. *Id.*

mothers.³⁸⁸ The babies' fates were irrevocably sealed according to Douglas Besharov, the former director of the National Center on Child Abuse, who originally coined the term "bio-underclass."³⁸⁹

News accounts of crack babies conflated the symptoms of prematurity with cocaine exposure. According to Dr. Claire Coles, Director of the Maternal Substance Abuse and Child Development Program (MSACD) at Emory University, the misrepresented accounts of babies shaking at birth were actually caused by prematurity.³⁹⁰ She informed *The New York Times* in 2013 that if reporters had focused on prematurity they would have observed the same trembling.³⁹¹

After decades of research, doctors have not "identified a recognizable condition, syndrome, or disorder that should be termed 'crack baby.'"³⁹² In a joint letter sent to media throughout the United States on February 25, 2004, thirty eminent medical doctors and researchers explained that the term was no longer defensible.³⁹³ By this time, numerous medical studies, including a few

388. *Id.*

389. In an opinion editorial, Besharov further ignited concerns about "bad mothers" and fetal crack exposure when he wrote that for "crack babies" their worst enemy was "mom herself." Besharov, *supra* note 380. He claimed that some infants exposed to crack, "are born with deformed hearts, lungs, digestive systems or limbs; others suffer what amounts to a disabling stroke while in the womb." Dramatic speculations bandied about as medical facts during the height of the drug war. Essentially, all medical challenges befalling African American offspring became read as conditions of crack exposure. For example, according to one reporter, fetal crack exposure allegedly caused babies to develop unusual genitalia. Pundits claimed that drug addicted women had "little or no interest in prenatal care." That pregnant addicts received limited prenatal care was explained as a matter of choice or deep disregard for fetal health, not fear of arrest and incarceration. Besharov, *supra* note 380.

390. *Crack Babies: A Tale From The Drug Wars: Retro Report*, (N.Y. TIMES May 20, 2013), available at <http://nyti.ms/116qYmh> (video interview with Claire Coles).

391. *Id.*

392. Lewis et al., *supra* note 373.

393. Scientists and doctors who signed the letter emphasized that their discontent derived "not merely [from] academic," or medical concern. They all fully agreed that the term lacked scientific validity. Rather, their concerns pertained to broader social and legal adoption of the term in media and potentially by courts. The doctors pointed to a New Jersey case where foster parents, Raymond and Vanessa Jackson, attempted to justify depriving children in their care of food. The parents argued that the children's underlying medical conditions, including the fact that one was an adolescent "crack baby" made it difficult for them to eat and was the reason why the four boys, ranging in age from nine to nineteen each weighed under fifty pounds. Ten years earlier, that justification might have carried significant sway given the irrational way in which American media stereotyped children of addicted mothers. Carol Ann Campbell, *MDs Doubt Jacksons' Explanation on Kids: Says Disorders Not Sole Cause in Starvation*, N.J. STAR LEDGER, Nov. 4, 2003, http://www.nj.com/news/ledger/index.ssf?/news/ledger/stories/20031104_childabuse_collingswood_doctors.html; Iver Peterson, *In Home That Looked Loving, 4 Boys' Suffering Was Unseen*, N.Y. TIMES, Oct. 28, 2003, <http://www.nytimes.com/2003/10/28/nyregion/in-home-that-looked-loving-4-boys-suffering-was-unseen.html>.

The letter represented another urgent appeal to newspapers, magazines, television networks, and news stations, "because media's use of these terms has led to a situation in which children can be starved and abused and the 'crack baby' label can be used to excuse the results." Among the signatories was Dr. Ira Chasnoff who decades before published studies, based on small research samples (twenty-six women in his original study) claiming a correlation between crack and dramatic

longitudinal research designs, repudiated the crack baby myth.³⁹⁴ More recently, on May 20, 2013, *The New York Times* acknowledged its complicity in the crack baby scare, noting that along with other news organizations, it published “articles and columns that went beyond the research.”³⁹⁵ The national narrative about crack exaggerated and misrepresented its health risks in fetuses.³⁹⁶ The so-called crack baby must be understood as a horrible, racially entrenched myth³⁹⁷ suffused with significant legal consequences unimagined at that time in any other prenatal context.

4. *Fetal Health Versus Business Interests: Alcohol and Tobacco*

As doctors began complying with fetal protection regulations by informing on their patients, and as courts swelled with the prosecutions of pregnant women for “delivering” crack to their fetuses,³⁹⁸ fetal impacts from alcohol consumption³⁹⁹ and cigarette smoking⁴⁰⁰ fell precipitously under the

fetal health outcomes. By signing the letter, he publically disavowed those prior conclusions. Lewis et al., *supra* note 373.

394. See Frank et al., *supra* note 121, at 1613, 1622–24 (concluding that no empirical evidence supports the claim that crack was more harmful “in severity, scope, or kind from the sequel of multiple other risk factors,” such as the child’s environment or poverty); Hurt et al., *Children with In Utero Cocaine Exposure do not Differ From Control Subjects on Intelligence Testing*, *supra* note 121, at 1241 (reporting no measurable differences between the intelligence test results of cocaine-exposed children and a control group at preschool age); Hurt et al., *School Performance of Children with Gestational Cocaine Exposure*, *supra* note 121, at 207 (finding no measurable distinction between children of school age exposed to crack and their cohort).

395. Michael Winerip, *Revisiting the ‘Crack Babies’ Epidemic that was Not*, N.Y. TIMES, May 20, 2013, http://www.nytimes.com/2013/05/20/booming/revisiting-the-crack-babies-epidemic-that-was-not.html?_r=0.

396. *Id.*

397. *Id.*

398. See, e.g., *Johnson v. State*, 578 So.2d 419 (Fla. Dist. Ct. App. 1991) (holding that cocaine passing through the umbilical cord after birth, but before the cord was cut, violated the state’s statutory prohibition against adult delivery of controlled substances to a minor), *decision quashed*, 602 So.2d 1288 (Fla. 1992).

399. Exposure to alcohol in utero is considered to be the leading cause of developmental disabilities. Blair Paley & Mary J. O’Connor, *Intervention for Individuals with Fetal Alcohol Spectrum Disorders: Treatment Approaches and Case Management*, 15 DEVELOPMENTAL DISABILITIES RES. REVS. 258, 258 (2009). Heavy consumption of alcohol during pregnancy places a fetus at significant risk for severe developmental challenges. Even light consumption of alcohol can produce negative impacts in the fetus. Researchers note that alcohol transfers from the gestators’ bloodstream to the developing fetus. The risks include interference with the fetal development of organs, including the brain. Researchers also find a correlation between facial distinctions and abnormalities, growth delays, and central nervous system disabilities. See Phillip A. May & Phillip Goassage, *Maternal Risk Factors for Fetal Alcohol Spectrum Disorders*, 34 ALCOHOL RES. & HEALTH 16 (2011); Kenneth R. Warren et al., *Fetal Alcohol Spectrum Disorders: Research Challenges and Opportunities*, 34 ALCOHOL RES. & HEALTH 4 (2011).

400. According to the CDC, women who smoke during pregnancy are more likely than women who do not smoke to experience miscarriage. The CDC also cautions that smoking can cause difficulties with the placenta, such as premature separation from the womb, causing risks to fetal and maternal health. Smoking during pregnancy is also linked to premature birth, low birth weight, cleft lip or cleft palate, death, and Sudden Infant Death Syndrome. *Tobacco Use and Pregnancy*, CDC,

radar.⁴⁰¹ It's worth thinking about why this occurred. The point of such an inquiry is not to add one more category of concern to the growing list of issues that states find relevant for punitive intervention; this Article rejects criminal intrusions in women's pregnancies.⁴⁰² It is worth thinking about why politicians carve out fetal protection exceptions for alcohol or tobacco use or addiction, particularly in light of the fact that U.S. women "are almost 20 times more likely to drink alcohol or smoke cigarettes than to use cocaine during pregnancy."⁴⁰³

<http://www.cdc.gov/Reproductivehealth/TobaccoUsePregnancy/index.htm> (last updated Jan. 28, 2014).

401. One explanation is that the crack scare and crack baby myth provided important social and cultural narratives in the United States that served as cover for the horrors of poverty. That children struggled in school, were irritable, or even violent could be explained by maternal addiction, rather than poverty. The profound poverty in urban inner cities, with crowded schools, limited preschool opportunities, increasing unemployment rates, particularly among African Americans, could be ignored—or addressed through attacks on pregnant women. Both occurred.

Crack addiction explained poverty; poor African Americans lived in dire conditions due to their drug use and refusal to work. Poor African American women became pregnant as a means of generating income through welfare. In his stump speeches, former President Ronald Reagan claimed, the "[welfare queen's] collecting social security on her cards. She's got Medicaid, getting food stamps, and she is collecting welfare under each of her [eighty] names." Reagan claimed that in 1976, the "welfare queen" generated \$150,000 per year in "tax-free cash." See *'Welfare Queen' Becomes Issue in Reagan Campaign*, N.Y. TIMES, Feb. 15, 1976, at 51.

The disparaging metaphor of the "welfare queen" overlapped with "crack babies" to depict crazed, selfishly unsympathetic African American women who "sell their food stamps" to get high. See Besharov, *supra* note 380. These were the bad mothers who supposedly did not care about their kids. The chief of neonatology at Bronx Lebanon Hospital commented to the *Washington Post*, "I've never seen mothers like this before." The doctor claimed that mothers addicted to crack "sell their bodies" in front of their children, because "these mothers don't care about their babies." It played into implicit and explicit biases about who uses drugs in this nation. See *id.* (quoting Dr. Jing Ja Yoon).

Reagan's compelling stump speeches throughout the country moved audiences to believe in the actual existence of this fictitious woman hoarding government resources—and there were many of them. He explained to a group in New Hampshire that "if you are a slum dweller, you can get an apartment with 11-foot ceilings, with a 20-foot balcony, a swimming pool . . ." and for only \$113.20 per month in rent. This too was not true, but it painted an image of urban "slum dwellers" and "welfare queens" usurping government resources while refusing to work. See *'Welfare Queen' Becomes Issue in Reagan Campaign*, *supra* (quoting Ronald Reagan's stump speech portrayal of a woman notoriously exploiting government assistance. Reagan claimed, "There's a woman in Chicago . . . she has 80 names, 30 addresses, 12 Social Security cards and is collecting veterans' benefits on four nonexistent deceased husbands.").

402. Rather, the concern is to distinguish known health risks from non-health risks, highlight the arbitrariness of fetal protection regulation overall, illumine the ways in which selective punishment regimes come about, and demonstrate that in light of other well-documented fetal-injurious activities—such as smoking and consuming alcohol during pregnancy—the absence of enforcement reveals that FPLs cannot justifiably be about fetal health. Instead, legislators are concerned about fetal health so long as profitable industries are not affected: pharmaceutical corporations, tobacco companies, and the alcoholic beverages industry.

403. Figdor & Kaeser, *supra* note 6, at 5 (citing National Institute on Drug Abuse). See also CENTER FOR BEHAVIORAL HEALTH STATISTICS AND QUALITY, RESULTS FROM THE 2010 NATIONAL SURVEY ON DRUG USE AND HEALTH: SUMMARY OF NATIONAL FINDINGS (2011) (finding that one in six pregnant women aged 15–44 smoked cigarettes within one month of the survey administered in 2009 and 2010 and discussing that cigarette use has dropped among pregnant women from 18 percent

My hunch is that business interests matter in the national debate about fetal health. In 1996, Justice Stephen G. Breyer explained that “unregulated tobacco use causes ‘[m]ore than 400,000 people [to] die each year from tobacco-related illnesses, such as cancer, respiratory illnesses, and heart disease.’”⁴⁰⁴ Breyer emphasized that “tobacco products kill more people in this country every year ‘than . . . AIDS, car accidents, alcohol, homicides, illegal drugs, suicides, and fires, *combined*.’”⁴⁰⁵ However, the majority in *Food and Drug Administration v. Brown & Williamson Tobacco Corporation* noted that although the FDA “amply demonstrated that tobacco use, particularly among children and adolescents, poses perhaps the single most significant threat to public health in the United States,” banning smoking would impose significant costs on a vital U.S. business interest.⁴⁰⁶

Notwithstanding smoking’s well-documented health risks,⁴⁰⁷ including the copiously detailed 978-page report issued in 2014 by the U.S. Surgeon General,⁴⁰⁸ federal legislators choose to exempt this activity from more aggressive government intervention measures to protect fetal health. The Court identified two clear reasons for this hands-off policy. First, smoking is a matter of consumer choice and the exercise of autonomous decision making, so as long as consumers receive adequate information about the health risks of smoking, Congress finds no reason to ban the activity. Second, federal legislators prioritize economic considerations in the case of smoking. The Supreme Court understood “Congress’s decisions to regulate labeling and advertising and to adopt the express policy of protecting ‘commerce and the national economy . . . to the maximum extent’” to reveal its intent that tobacco

to just over 16 percent), *available at* <http://www.samhsa.gov/data/nsduh/2k10nsduh/2k10results.htm#4.3>.

404. *Food & Drug Admin. v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 162 (2000) (Breyer, J., dissenting) (citing 61 Fed. Reg. 44,398 (1996)).

405. *Id.*

406. *Id.* at 161.

407. For example, while Congress recognizes the detrimental health risks associated with cigarette smoking (and secondhand smoke) as demonstrated by at least six congressional hearings since 1965, it has “[n]onetheless . . . stopped well short of ordering a ban. Instead, it has generally regulated the labeling and advertisement of tobacco products, expressly providing that it is the policy of Congress that ‘commerce and the national economy may be . . . protected to the maximum extent consistent with’ consumers ‘be[ing] adequately informed about any adverse health effects.’” *See id.* at 138–39. Despite known health risks, “Congress . . . has foreclosed the removal of tobacco products from the market.” A provision of the United States Code currently in force states that “[t]he marketing of tobacco constitutes one of the greatest basic industries of the United States with ramifying activities which directly affect interstate and foreign commerce at every point, and stable conditions therein are necessary to the general welfare.” *Id.* at 137 (citing 7 U.S.C. § 1311(a)).

408. U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, *THE HEALTH CONSEQUENCES OF SMOKING—50 YEARS OF PROGRESS: A REPORT OF THE SURGEON GENERAL* [hereinafter *THE HEALTH CONSEQUENCES OF SMOKING*] (2014), *available at* <http://www.surgeongeneral.gov/library/reports/50-years-of-progress/>.

products remain on the market.”⁴⁰⁹ The Court’s ruling in *Food and Drug Administration v. Brown & Williamson Tobacco Corporation* makes clear that the known health risks and costs associated with smoking,⁴¹⁰ do not trump market considerations and financial interests.

Nevertheless, the 2014 Surgeon General Report on smoking explains that its effects extend from fertility through gestation and beyond, resulting in cases of fetal growth restriction, preterm delivery, placenta previa, placental abruption, some congenital abnormalities,⁴¹¹ and impaired lung development.⁴¹² Because over four hundred thousand infants experience in utero exposure to tobacco from maternal smoking, the consequences should not be ignored, just as they should not be unaddressed in the cases of women dependent on illicit drugs. From a health perspective, the question remains one of providing care and support to pregnant women. The reproductive repercussions associated with smoking, however, affect not only women’s reproductive health, but also men’s.⁴¹³ According to Dr. Boris Lushniak, the acting Surgeon General, “cigarette use before and/or during pregnancy remains a major cause of reduced fertility as well as a maternal, fetal, and infant morbidity and mortality in the United States.”⁴¹⁴

409. *Food & Drug Admin.*, 529 U.S. at 139 (“A ban of tobacco products by the FDA would therefore plainly contradict congressional policy.”). Joseph R. DiFranza et al., *Legislative Efforts to Protect Children From Tobacco*, 257 JAMA 3387, 3387–89 (1987) (noting the passage of public health laws to reduce the incidence of child smoking, but noting that legislative efficacy was so lax that an eleven-year-old was able to purchase cigarettes in seventy-five of one hundred attempts).

410. More recently, Dr. Boris D. Lushniak, the acting Surgeon General for the United States, expanded the list of smoking-related illnesses to include colorectal and liver cancers, diabetes, vision loss, tuberculosis, rheumatoid arthritis, impaired immune function, and cleft palates in offspring of women smokers. Although not legally binding, the report nevertheless represents “a standard for scientific evidence among researchers and policy makers.” See Jane Brody, *Coming A Long Way on Smoking With a Long Way To Go*, N.Y. TIMES BLOG (Jan. 20, 2014), <http://well.blogs.nytimes.com/2014/01/20/coming-a-long-way-on-smoking-with-a-way-to-go/?ref=smokingandtobacco> (highlighting the fact that this year marks the 50th anniversary of the first surgeon general report warning about the cancerous effects of smoking and “in the decades since the 1964 report, damning evidence for the health hazards of smoking has continued to mount.”); THE HEALTH CONSEQUENCES OF SMOKING, *supra* note 408; Editorial Board, *Fitful Progress in the Antismoking Wars*, N.Y. TIMES, Jan. 9, 2014, http://www.nytimes.com/2014/01/10/opinion/fitful-progress-in-the-antismoking-wars.html?_r=0 (“nearly 44 million American adults still smoke, more than 440,000 Americans die every year from smoking, and eight million Americans live with at least one serious chronic disease from smoking.”); Sabrina Tavernise, *List of Smoking-Related Illnesses Grows Significantly in U.S. Report*, N.Y. TIMES, Jan. 17, 2014 (noting among a list of various diseases such as lung cancer, heart disease, and diabetes, smoking is correlated with ectopic pregnancies), <http://www.nytimes.com/2014/01/17/health/list-of-smoking-related-illnesses-grows-significantly-in-us-report.html>.

411. THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, THE HEALTH CONSEQUENCES OF SMOKING—50 YEARS OF PROGRESS: A REPORT OF THE SURGEON GENERAL at 117–18 (2014), available at <http://www.surgeongeneral.gov/library/reports/50-years-of-progress/>.

412. *Id.* at 120.

413. *Id.* at 68.

414. *Id.*

5. *The Scapegoat: Retribution and Punishment*

If fetal protection efforts are not about the health of fetuses, what function(s) do they serve? Increasingly fetal interventions are asserted to vindicate the interests of fetuses and the state.⁴¹⁵ Viewed in this context, the laws are at least as much, if not more, about formal retribution and punishment as their alleged goal of protecting fetal health. In this way, states seek to protect the purported dignity interests of fetuses against the perceived reckless, lazy, and negligent conduct of “bad mothers.”⁴¹⁶

This image of the bad mother is depicted and personified in deeply racialized ways in U.S. society.⁴¹⁷ The crack scare provides one disturbing example. Another is the notorious welfare queen.⁴¹⁸ FPLs play into faulty cultural constructs about race and responsibility and can be motivated by what Professor Dorothy Roberts referred to as “ethnocentric” values and conceptions.⁴¹⁹ That is, states seek to intervene in women’s pregnancies on health grounds rooted in historic racial and class stereotyping and bias, as the

415. Condon, *supra* note 56 (justifying his metaphoric use of the “stick” in implementing fetal protection). Condon referred to drug addiction as a “blatant” form of child abuse.

416. See Roberts, *supra* note 5, at 1424.

417. FRANKLIN D. GILLIAM, JR., THE “WELFARE QUEEN” EXPERIMENT: HOW VIEWERS REACT TO IMAGES OF AFRICAN AMERICAN MOTHERS ON WELFARE (1999), available at <http://www.nieman.harvard.edu/reportsitem.aspx?id=102223> (discussing how white Americans are exposed to welfare narratives that depict African American women as recipients and as a result whites are less likely to be supportive of welfare programs, are more likely to stereotype African American women, and more likely to embrace patriarchy).

418. The welfare queen mythology came to be associated with African American women. Catherine Albiston & Laura Beth Nielson, *Welfare Queens and Other Fairy Tales: Welfare Reform and Unconstitutional Reproductive Controls*, 38 HOW. L.J. 473, 475 (1995) (articulating that “attacks on ‘welfare cheats’ are directed at black mothers in particular”). Throughout the second half of the twentieth century, depictions of welfare recipients were often women of color. *Id.* These images were sometimes quite exaggerated and focused on the most needy of women as the most deprived and irresponsible: single with multiple children. As Ronald Reagan ran for President, he frequently warned audiences about the greedy welfare queens usurping government resources. See, e.g., KAARYN S. GUSTAFSON, CHEATING WELFARE: PUBLIC ASSISTANCE AND THE CRIMINALIZATION OF POVERTY (2011) (discussing how the perception of fraud and deception now pervades public understanding about welfare, which in turn has resulted in welfare policies becoming more punitive); John Blake, *Return of the Welfare Queen*, CNN, Jan. 23, 2012, <http://www.cnn.com/2012/01/23/politics/welfare-queen/> (discussing the use of the “welfare queen” imagery during political campaign seasons, cynically warning that “[s]he’s out there, lurking in the 2012 presidential race like a horror movie villain who refuses to die”); Josh Levin, *The Welfare Queen*, SLATE (Dec. 19, 2013), http://www.slate.com/articles/news_and_politics/history/2013/12/linda_taylor_welfare_queen_ronald_reagan_made_her_a_notorious_american_villain.html (“Reagan’s soliloquies on welfare fraud are often remembered as shameless demagoguery.”); NewsOne Staff, *Linda Taylor: Ronald Reagan’s Welfare Queen Was Real...And White*, Dec. 29, 2013, <http://newsone.com/2819010/linda-taylor-ronald-reagans-welfare-queen-was-real-and-white/> (remarking that President Reagan made it his mission to vilify African American women as defrauders of welfare when the person he alluded to was actually a white woman); *‘Welfare Queen’ Becomes Issue in Reagan Campaign*, *supra* note 401 (documenting then Governor Reagan’s clever imagery of the “welfare queen” who pillages from government).

419. Roberts, *supra* note 5; Dorothy Roberts, *Unshackling Black Motherhood*, 95 MICH. L. REV. 938, 939 (1997) (explaining that FPLs seek to punish African American women for having babies).

grossly selective prosecutions in *Ferguson* demonstrated.⁴²⁰ In that case, prosecutors never implemented their drug scheme in the private obstetrics practice of the Medical University of South Carolina—only in the public care practice,⁴²¹ thereby not only implicitly associating low-income women with “bad motherhood,”⁴²² but shielding wealthier, white women from any possibility of such characterizations.⁴²³ As a result, doctors as well as prosecutors could and did create false narratives about drug use and addiction in pregnancy, focusing only on one drug—crack—and primarily screening only African Americans for crack.

African American women have been the selective targets of prurient state interest for centuries.⁴²⁴ Professor Dorothy Roberts refers to their selective

420. In *Ferguson*, twenty-nine of thirty patients arrested at one hospital were poor, African American women. Brief for Petitioners at 13, *Ferguson v. Charleston*, 532 U.S. 67 (2001) (No. 99-936), 2000 WL 33599645. Roberts compares the prosecution in *Skinner* to that of drug addicted African American women, arguing that although these prosecutions are different, they are “dangerous for similar reasons.” Roberts, *supra* note 5, at 1419.

421. Figdor & Kaeser, *supra* note 6, at 5.

422. A rich scholarship on law and motherhood provides contours for a discussion on law and “bad motherhood.” While no one trait defines “bad motherhood” in the socio-political contexts, several recurring themes emerge in a review of scholarship. Historically, motherhood has concerned race and class to the exclusion of certain classes of women from ever attaining a legal or social status of being good mothers or mothers at all. Eugenics laws introduced in the early twentieth century in the United States deprived tens of thousands of poor women from ever achieving the status of motherhood. In *Buck v. Bell*, Justice Oliver Wendell Holmes opined that “three generations of imbeciles are enough” to justify the state depriving women from “continuing their kind.” The nation’s poor women were doomed to be this nation’s “bad mothers,” because they were indigent, lacked property, often could not vote, and sometimes reared their children as single parents. See Annette Appell, “Bad Mothers” and Spanish Speaking Caregivers, 7 NEV. L.J. 759 (2007) (noting that “we have in this country a long and continuing history of constructing the ideal of ‘mother’ according to skin color, religion, culture, national origin, language, ethnicity, class, and marital status.”); Kimberlé Crenshaw, *From Private Violence to Mass Incarceration: Thinking Intersectionally About Women, Race, and Social Control*, 59 UCLA L. REV. 1418 (2012) (discussing the structural and political dimensions of mass incarceration and gender bias, exposing how they are interconnected in multiple ways); Martha Fineman, *Images of Mothers In Poverty Discourses*, 1991 Duke L.J. 274 (1991) (explaining the role of patriarchal discourse in framing welfare recipients as “constituting the cause as well as the effect of poverty”); Robin Levi et al., *Creating The “Bad Mother”: How The U.S. Approach To Pregnancy In Prisons Violates The Right To Be A Mother*, 18 UCLA WOMEN’S L.J. 1, (2010); Jane Murphy, *Legal Images Of Motherhood: Conflicting Definitions From Welfare “Reform,” Family, And Criminal Law*, 83 CORNELL L. REV. 688, 689 (1998) (analyzing that criminal law provides a lens to see who the nation values as “good mothers” and who is tossed away as “bad” mothers); Sonia Suter, *Bad Mothers or Struggling Mothers?*, 42 RUTGERS L. J. 695, 701–02 (2011) (explaining that above all else good birth is not likely what fetal drug laws are about, but instead presumptions about class influencing perceptions about bad motherhood).

423. See *Ferguson v. Charleston*, 532 U.S. 67 (2001). According to a recent law review article written by human rights attorneys, white women who make up over 76 percent of California’s population are underrepresented in its prisons. African American women, on the other hand, make up less than 8 percent of the state’s population and represent 29.3 percent of the women’s prison population. Levi et al., *supra* note 422, at 7.

424. Albiston & Nielson, *supra* note 418, at 477 (providing a historic overview of African American women’s reproduction, noting “neither the exclusion of black women from social welfare programs nor control of their reproductive freedom are new social policies; even the connection

scrutiny from the state as resulting from “inseparable combination[s] of their gender, race, and economic status.”⁴²⁵ But why have African American women become the subjects of contemporary scorn and reproductive policing?

Twenty years ago, Dr. Ira Chasnoff explained to a *New York Times* reporter that significant racial disparities in fetal interventions persisted despite evidence of “equal rates of drug use” among white women and women of color, because “our perception of who a drug abuser is”⁴²⁶ influences who is reported to law enforcement. In other words, there was no empirical foundation that justified disparate arrests rates; African Americans’ use of illicit drugs was no greater than that of their white counterparts. Nevertheless, as Chasnoff explained, “there is a perception that the people using drugs are mostly minority, inner-city people.”⁴²⁷

Lynn Paltrow’s research demonstrates that race continues to drive state interventions in pregnancy,⁴²⁸ though recent prosecutions of poor, white women in Alabama have exposed a different, but equally precarious, type of profiling. States make an example of “bad mothers” by subjecting them to punitive state measures ranging from civil confinement to criminal incarceration. Meanwhile, states ignore the extralegal punishment⁴²⁹ of pregnant women, precisely because the extralegal humiliations and stigmatization serve an implicit retributive purpose connected with purported fetal protection goals. What else realistically justifies the barbarity of shackling pregnant women during labor and birth?⁴³⁰ For example, Minnesota law permits the “use of full restraints—waist, chain, black box over handcuffs and leg irons—during transportation of an inmate for the purpose of giving birth.”⁴³¹

Importantly, neither the health interest nor the retribution justifications for state intervention in women’s pregnancy are satisfactory. While promoting fetal health is a laudable goal, the state cannot exert unconstitutional authority on its

between these policies is old.”). See also Roberts, *supra* note 5, at 1437–39 (noting that “[t]he myth of the ‘bad’ Black woman was deliberately and systematically perpetuated after slavery”).

425. Roberts, *supra* note 5, at 1424.

426. Gina Kolata, *Bias Seen Against Pregnant Addicts*, N.Y. TIMES, July 20, 1990, at A13 (quoting Dr. Ira Chasnoff).

427. *Id.*

428. Paltrow & Flavin, *supra* note 4, at 303 (noting that racial and class disparities persist in fetal interventions). African American women are ten times more likely than their white counterparts to be reported to child protective services for drug use during pregnancy. *Id.*

429. For a reading on the legal implications of shackling, see INTERNATIONAL HUMAN RIGHTS CLINIC ET AL., *supra* note 332; Geraldine Doetzer, *Hard Labor: The Legal Implications of Shackling Female Inmates During Pregnancy and Childbirth*, 14 WM. & MARY J. WOMEN & L. 365 (2008); Claire Griggs, *Birthing Barbarism: The Unconstitutionality of Shackling Pregnant Prisoners*, 20 AM U.J. GENDER SOC. POL’Y & L. 247 (2011); Ocen, *supra* note 339.

430. Griggs, *supra* note 429 (debunking state justifications for shackling pregnant women prisoners, including concerns about safety, escape, and recidivism deterrence).

431. Griggs, *supra* note 429, at 266, 266 n.161 (citing MINN. STAT. ANN. §241.07 (West 2011)).

citizens to achieve that objective. As importantly, to the extent that states articulate a sincere desire to promote fetal health, appreciating that maternal conduct and health alone do not control fetal health outcomes is crucial. States unyielding gaze on low-income, pregnant women as “maternal environments” or “containers”⁴³² ignores the myriad ways in which fetal health may be shaped by the environment,⁴³³ stress,⁴³⁴ and poverty⁴³⁵ that pregnant women encounter, but do not control.

B. Equal Protection and Pregnancy

Scholarly responses to attacks on reproductive liberty are significantly situated in liberal notions of substantive due process, offering persuasive arguments that women’s autonomy and privacy deserve the protections of the Fourteenth Amendment’s Due Process Clause.⁴³⁶ The principle arguments that ground liberal substantive due process analysis in reproduction relate to the infringement on women’s individual autonomy and personhood as well as the

432. George J. Annas, *Pregnant Women as Fetal Containers*, 16 HASTINGS CTR. REP. 13 (1986); Lucinda J. Peach, *From Spiritual Descriptions to Legal Prescriptions: Religious Imagery of Woman as “Fetal Container” in the Law*, 10 J. L. & RELIGION 73(1994).

433. Harmful environmental agents are linked to cancer, infertility, and many other chronic illnesses. Robert Brent et al., *A Pediatric Perspective on the Unique Vulnerability and Resilience of the Embryo and the Child to Environmental Toxicants: The Importance of Rigorous Research Concerning Age and Agent*, 113 PEDIATRICS 935(2004); Robert Brent, *Environmental Causes of Human Congenital Malformations: The Pediatrician’s Role in Dealing With These Complex Clinical Problems Caused by a Multiplicity of Environmental and Genetic Factors*, 113 PEDIATRICS 957 (2004).

434. Stress during gestation is associated with premature birth and hyperactivity during childhood. Severe stress during pregnancy, such as experiencing natural disasters, is linked to risk of mental illness, such as severe depression and schizophrenia, in adult offspring. J.A. DiPietro, *The Role of Maternal Stress in Child Development*, 13 CURRENT DIRECTIONS IN PSYCHOL. SCI. 71 (2004); A.C. Huizink et al., *Prenatal Stress and Risk for Psychopathology: Specific Effects or Induction of General Susceptibility?*, 130 PSYCHOL. BULL. 115 (2004).

435. Professor Emeritus Dan Agin argues that poverty transforms into inherited disease in urban inner cities and rural communities. He associates poverty with hazardous exposure to neurotoxins in the environment. He points to studies examining low-income pregnant women’s exposure to lead, which is correlated with low birth weight, hearing loss, attention deficits, autism, and other conditions affecting fetal development and child health, including death. See Dan Agin, *MORE THAN GENES: WHAT SCIENCE CAN TELL US ABOUT TOXIC CHEMICALS, DEVELOPMENT, AND THE RISK TO OUR CHILDREN* 25–26 (2009). Agin notes that pesticides play a unique role in fetal health that is largely associated with poverty. For example, he explains that insecticides to rid environments of roach infestation may account for the presence of those toxins found in pregnant women in low income neighborhoods in New York City. See *id.* See also Charles Larson, *Poverty During Pregnancy*, 12 PEDIATRICS & CHILD HEALTH 673, 673 (2007) (explaining that poverty’s impact on pregnancies may result in long-term outcomes, including “greatly increased risks for preterm birth, intrauterine growth restriction, and neonatal or infant death”).

436. See, e.g., *supra* note 5, at 1463 (arguing that the prosecutions of African American women “violate traditional liberal notions of privacy”). Roberts adds to this an equality framework that specifically addresses the unique interests of African American women. See also Anita Allen, *Taking Liberties: Privacy, Private Choice, and Social Contract Theory*, 56 U. CIN. L. REV. 461 (1987) (arguing that privacy also includes autonomous decision making); Oberman, *supra* note 12.

invidious force imposed by the government in women's childbearing, which unconstitutionally burdens a fundamental right. These concerns root quite simply in the right to be "let alone" and "left alone" both as matters of decisional autonomy and as matters of flesh—to be free from the physical impositions of others.

Much of the reproductive health scholarship borrows from the individual liberty framework established by the Supreme Court in *Roe v. Wade*,⁴³⁷ which situates constitutional protections for the right to procreate as well as to terminate a pregnancy in the Due Process Clause. In *Roe*, the Court reasoned that the right to privacy applies across a set of intimate life decisions, including "activities relating to marriage . . . procreation, . . . contraception, . . . family relationships, . . . and child rearing and education."⁴³⁸

This Article takes up a different challenge, descriptively and normatively reasserting the relevance of an equality framework in women's reproductive health generally,⁴³⁹ and specifically as applied to fetal protection cases in pregnancy such as those described in this Article. A sex equality argument in the fetal protection context would ask whether state interventions are really about promoting fetal health, or whether FPLs might also manifest constitutionally repugnant judgments about women, particularly pregnant women.⁴⁴⁰

The application of an equality lens to answer punitive fetal health interventions in women's pregnancies reflects a concern that states uniquely enlist law enforcement (including doctors acting in a quasi-state agent capacity) to deploy their interests in gendered ways. If states deploy their fetal health interests in gendered ways, might that sex-selective approach indicate constitutionally suspect motivations? When states manifest their interests in

437. 410 U.S. 113, 152 (1973). The *Roe* Court concluded that "the right of privacy [is founded] in the Fourteenth Amendment's concept of personal liberty." *Id.* (delineating that a right to privacy extends across intimate life decisions). This approach sidelined suspect classification equality arguments such as had been previously urged by Ruth Bader Ginsburg and legal scholars. Before *Reed v. Reed*, the Supreme Court did not recognize sex discrimination as presenting any special constitutional concern. 404 U.S. 71 (1971) (holding that the Equal Protection Clause forbade states from enacting laws that treated distinct classes of people differently based on reasons unrelated to the purpose of the statute). Justice Blackmun in particular found the equal protection analysis put forth by Ginsburg (then a lawyer for the ACLU) to be "contrived," with "overbearing arguments." However, Blackmun's deliberations on women's equality evolved throughout his tenure on the bench. Linda Greenhouse suggests that he "came slowly to the cause of women's equality." Linda Greenhouse, *The Evolution of a Justice*, N.Y. TIMES MAG., April 11, 2005, <http://www.nytimes.com/2005/04/10/magazine/10BLACKMUN.html?pagewanted=print&position=>

438. *Roe*, 410 U.S. at 152. See also *Loving v. Virginia*, 388 U.S. 1, 12 (1967) ("[m]arriage is one of the 'basic civil rights of man' fundamental to our very existence and survival."); *Michael H. v. Gerald D.*, 491 U.S. 110 (1989) (applying a due process analysis in paternity).

439. See Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to Roe v. Wade*, 63 N.C. L. REV. 375 (1985); Catharine MacKinnon, *Reflections on Sex Equality Under Law*, 100 YALE L. J. 1281 (1991).

440. Neil S. Siegel & Reva B. Siegel, *Equality Arguments for Abortion Rights*, 60 UCLA L. REV. 160, 163 (2013).

fetal health, they express these concerns almost exclusively among poor women who lack the social and economic capacities that protect wealthier, educated women from similar punitive encroachments by the state.

For example, when states pressure physicians to subject poor African American pregnant patients to invasive protocols as a means to determine illicit drug use in furtherance of fetal health, but significantly exclude white female patients from similar interventions, that disparity indicates a suspect motivation not explained by health or law rationales.⁴⁴¹ Equally, when punitive fetal protection efforts operate exclusively in indigent communities (or where the indigent seek care) and not universally, such actions reflect decision making that carves out unjustifiable, discriminatory distinctions between classes of citizens that have no relationship to a permissible governmental purpose. Such distinctions might reasonably be explained by constitutionally impermissible stereotypes about good motherhood, maternal responsibility, and citizenship guiding legislative action. Such stereotypes might be argued to resemble caste legislation or caste enforcement. When this type of legislating cannot be shown to further its purported governmental interest, it proves itself to be arbitrary.⁴⁴²

A sex equality framework is not only concerned about distinctions among women.⁴⁴³ To the contrary, distinctions between sexes are no more permissible

441. A clear example of an impermissible standard of equality would be if states were to discriminate against those persons legally entitled to have access to abortion services, limiting the right to only one ethnic group, for example, or distinguishing the right as between married versus unmarried women.

442. Traditionally, equal protection granted states broad latitude to enact legislation. States' low threshold was a rational basis test. That is, courts required that the challenged legislation be rationally related to a permissible governmental interest. Under this framework, states needed only show that the classification set forth in the legislation rationally related to a legitimate government interest and that such state action was not arbitrary. *Gulf, C. & S.F. Ry. v. Ellis*, 165 U.S. 150 (1897) (applying equal protection to strike down a law mandating that railroads, but not other defendants, pay attorney's fees to prevailing plaintiffs). Modern Supreme Court application has involved three tiers of review: strict scrutiny in racial classifications (requiring the state's regulation to further a compelling governmental interest); a heightened intermediary scrutiny in of sex discrimination (requiring that the legislation serve important governmental objectives and be substantially related to achieve those goals); and it has maintained a rational relationship level of review (requiring only a rational relationship to legitimate governmental ends).

443. *Skinner v. Oklahoma*, 316 U.S. 535 (1942) (an unanimous Court holding that where Oklahoma's Criminal Sterilization Act provided for the sterilization of habitual criminals convicted three times or more of felonious crimes of moral turpitude, but provided exclusions for white collar criminals, such regulations violated the Equal Protection Clause of the Fourteenth Amendment). *See also* *Planned Parenthood v. Casey*, 505 U.S. 833 (1992) (reaffirming its opinion in *Roe*, holding that the liberty and privacy interests that animated the Court's decision in *Roe* remained vital in the protection of a substantive right to privacy and that this right is protected from interference in "marriage, procreation, contraception, family relationships, child rearing, and education."); *Kirchberg v. Feenstra*, 450 U.S. 455 (1981) (holding that the state of Louisiana failed to demonstrate an important interest in permitting husbands the authority to unilaterally dispose of joint property); *Wengler v. Druggists Mut. Ins. Co.*, 446 U.S. 142 (1980) (holding that the provision of the Missouri workers' compensation laws denying a widower benefits on his wife's work-related death unless he either is mentally or physically incapacitated or proves dependence on his wife's earnings, but granting a widow death benefits without her having to prove dependence on her husband's earnings, violates the

than distinctions within sexual classifications.⁴⁴⁴ Distinctions between sexes to advance fetal health might reify stereotypes and ignore medical facts. For example, when the state uniquely and exclusively calls upon women, but not men, to advance fetal health, it does so under the flawed theory that women alone determine fetal health. Such regulations, then, reduce women to symbolic wombs and human incubators for the state. When states selectively express and enforce fetal health interests, distinguishing between the sexes and among the sexes, such considerations belie an interest in protecting fetal health. Instead, states' selective interest in protecting fetal health reflects adverse stereotypes about women and pregnancy. The Supreme Court has ruled that such arbitrary rules about pregnancy cannot stand.⁴⁴⁵

1. *Geduldig v. Aiello: An Equality Hurdle?*

Scholars hesitant of this line of argumentation point to *Geduldig v. Aiello*⁴⁴⁶ as feminism's lost battle on equal protection and pregnancy. Scholars read that 1974 case as closing the door for equal protection claims by pregnant women.⁴⁴⁷ The case has also been construed to infer that that not all

Equal Protection Clause of the Fourteenth Amendment"). Similarly in *Califano v. Goldfarb*, 430 U.S. 199 (1977), the Court reached a plurality decision, pointing out that where "female insureds received less protection for their spouses solely because of their sex" that such circumstances were a discriminatory violation of the Fifth Amendment's equal protection guarantee. See also *Caban v. Mohammed*, 441 U.S. 380 (1979) (holding that a state law violates the Equal Protection Clause when it permits the mother, but not the father of a child born out of wedlock to intervene in the child's adoption).

444. See *J.E.B. v. Alabama ex rel. T.B.*, 511 U.S. 127 (1994) (holding that peremptory challenges based on juror sex are unconstitutional); *Miss. Univ. v. Hogan*, 458 U.S. 718 (1982) (sustaining a male applicant's challenge to the state's policy that excluded men from the Mississippi University for Women); *Craig v. Boren*, 429 U.S. 190 (1976) (finding that sex does not represent "a legitimate, accurate proxy for the regulation of drinking and driving"); *Frontiero v. Richardson*, 411 U.S. 677 (1973) (sustaining an equal protection challenge to a federal law providing male members of the armed forces an automatic dependency allowance for their wives while denying the same for female service members); *Reed v. Reed*, 404 U.S. 71 (1971).

445. *Int'l Union v. Johnson Controls*, 499 U.S. 187, 188 (1991).

446. 417 U.S. 484 (1974) (addressing pregnancy classifications, holding that "disability that accompanies normal pregnancy and birth" does not constitute invidious discrimination).

447. For a catalogue of the articles criticizing the *Geduldig* opinion, see Sylvia A. Law, *Rethinking Sex and the Constitution*, 132 U. PA. L. REV. 955, 983 (1984) ("Criticizing *Geduldig* has since become a cottage industry."). More recently one scholar has suggested that "[t]he only reason state-mandated health insurance without contraception coverage does not raise serious Equal Protection Clause issues is because of an ill-reasoned, much-derided Supreme Court decision (by an all-male Court) holding that pregnancy discrimination was not sex discrimination." See Caroline Mala Corbin, *The Contraception Mandate*, 107 Nw. U. L. Rev. Colloquy 151, 161–62 n.63 (2012). A student note lamented, "the Equal Protection Clause of the Fourteenth Amendment appears to provide no additional protection for the pregnant woman seeking to challenge a court-ordered cesarean." Eric Levine, Note, *The Constitutionality of Court Ordered Cesarean Surgery: A Threshold Question*, 4 ALB. L.J. SCI. & TECH. 229, 301 (1994).

For a brief list of commentary immediately following the opinion, see Katharine Bartlett, *Pregnancy and the Constitution: The Uniqueness Trap*, 62 CALIF. L. REV. 1532, 1536 (1974) (criticizing the Court's "failed logic"); Phillip Cockrell, *Pregnancy Disability Benefits and Title VII:*

classifications that discriminate against women or disadvantage them as a class or a subclass are necessarily based on sex. In that case, California's disability insurance program, which mandated participation, exempted work missed due to normal pregnancies from insurable coverage.⁴⁴⁸ It is worth noting that the original language exempted all pregnancies, even those requiring medicalization over eight days, from coverage.⁴⁴⁹

In the lawsuit, four petitioners—three of whom experienced abnormal pregnancies resulting in terminations and miscarriages and one of whom experienced a normal pregnancy—argued that the program violated the Equal Protection Clause because it precluded the payment of benefits for any disability resulting from pregnancy.⁴⁵⁰ This particular issue was moot on hearing as the law had been changed to reflect pregnancy coverage for disabling conditions, which would cover the pregnancy concerns of three of the

Pregnancy Does Not Involve Sex?, 29 BAYLOR L. REV. 257 (1977); Ruth Bader Ginsburg, *Gender in the Supreme Court: the 1973 and 1974 Terms*, 1975 SUP. CT. REV. 1; Ruth Bader Ginsburg, *Gender and the Constitution*, 44 U. CIN. L. REV. 1 (1975); Ruth M. Ferrell, *The Equal Rights Amendment to the United States Constitution—Areas of Controversy*, 6 URB. LAW. 853 (1974); Harriet Hubacker Coleman, *Barefoot and Pregnant—Still: Equal Protection for Women in Light of Geduldig v. Aiello*, 16 S. TEX. L.J. 211 (1975).

448. The program was funded entirely from contributions deducted from wages earned by participating employees. Each worker was required to contribute one percent of her annual salary not to exceed eighty-five dollars. *Geduldig v. Aiello*, 417 U.S. 484, 487-88 (1974) (noting that "[I]t is not every disabling condition, however, that triggers the obligation to pay benefits under the program. As already noted, for example, any disability of less than eight days' duration is not compensable, except when the employee is hospitalized. Conversely, no benefits are payable for any single disability beyond 26 weeks.")

449. The policy imposed other limitations regarding minimum days of hospitalization necessary to trigger the program as well as provisions that precluded coverage over a maximum state. *Id.*

450. *Id.* The relevant original statute read:

'Disability' or 'disabled' includes both mental or physical illness and mental or physical injury. An individual shall be deemed disabled in any day in which, because of his physical or mental condition, he is unable to perform his regular or customary work. *In no case shall the term 'disability' or 'disabled' include any injury or illness caused by or arising in connection with pregnancy up to the termination of such pregnancy and for a period of 28 days thereafter.* Cal. Unemp. Ins. Code § 2626. *Id.* at 489.

The regulation was modified prior to the Supreme Court hearing on the matter to include pregnancy coverage for disabling pregnancies.

§ 2626 'Disability' or 'disabled' includes both mental or physical illness, mental or physical injury, and, to the extent specified in Section 2626.2, pregnancy. An individual shall be deemed disabled in any day in which, because of his physical or mental condition, he is unable to perform his regular or customary work."

§ 2626.2 Benefits relating to pregnancy shall be paid under this part only in accordance with the following:

(a) Disability benefits shall be paid upon a doctor's certification that the claimant is disabled because of an abnormal and involuntary complication of pregnancy, including but not limited to: puerperal infection, eclampsia, caesarian section delivery, ectopic pregnancy, and toxemia.

(b) Disability benefits shall be paid upon a doctor's certification that a condition possibly arising out of pregnancy would disable the claimant without regard to the pregnancy, including but not limited to: anemia, diabetes, embolism, heart disease, hypertension, phlebitis, phlebothrombosis, pyelonephritis, thrombophlebitis, vaginitis, varicose veins, and venous thrombosis. *Id.* at 490, n.15

four petitioners.⁴⁵¹ Nevertheless, the Court issued a ruling grounded in an economic rational basis analysis,⁴⁵² rejecting the application of an equal protection framework on the basis that excluding normal pregnancies did not constitute invidious discrimination.⁴⁵³

Justice Potter Stewart's majority opinion might give the cautious reader reason to construe the case as at least deflecting equal protection analysis from applying to pregnancy if not outright rejecting pregnancy as possibly qualifying for equal protection. In a much-derided footnote, Justice Stewart wrote, "the California insurance program does not exclude anyone from benefit eligibility because of gender but merely removes one physical condition—pregnancy—from the list of compensable disabilities."⁴⁵⁴ Yet, there is more to be said contextually about the *Geduldig* Court and subsequent iterations of equality before the Supreme Court both as descriptive and normative matters.⁴⁵⁵ So how should we understand *Geduldig*?

First, it is important to understand what the case actually does and does not say. For example, the Court does not dismiss pregnancy as never qualifying for protection under the equality standard guaranteed by the Fourteenth Amendment. Neither does the Court issue a resounding rejection of the principle that pregnancy regulation can be sex regulation, and therefore can be discriminatory. The Court did not hold that discrimination based on pregnancy deserves a lower level of review and classification than cases that involve sex. The Court held that state regulations affecting pregnancy are not always suspect of sex discrimination. When a regulation is not suspect of sex, as when it is not suspect of race, a rational basis analysis will be used.⁴⁵⁶ Instead, Justice

451. *Id.* at 490.

452. For some, *Geduldig* represents a clear iteration for the Court that pregnancy is not suspect because the level of scrutiny afforded to this class did not reflect the recent precedents in *Frontiero* and *Reed*. But a more nuanced reading of the case is warranted. As Reva Siegel notes, "the conventional wisdom about *Geduldig* . . . is incorrect." See Siegel & Siegel, *Equality Arguments for Abortion Rights*, *supra* note 440, at 167.

453. The majority held: (1) California has a legitimate interest in maintaining the self-supporting nature of its insurance program; (2) the state had an interest in "distributing the available resources in such a way as to keep benefit payments at an adequate level for the conditions covered; and (3) California "has a legitimate concern in maintaining the contribution rate at a level that will not unduly burden participating employees, particularly low-income employees who may be most in need of the disability insurance." 417 U.S. 484, 496 (1974).

454. *Id.*

455. Siegel & Siegel, *supra* note 440.

456. Siegel & Siegel, *supra* note, at 167 (noting that "one commonly cited objection to building an equality framework for abortion rights under the Court's existing equal protection jurisprudence is the Court's . . . decision in *Geduldig v. Aiello*").

456. This is not to say that the holding is not disappointing, particularly in light of insurance programs' regulations regarding reproduction. The Court makes note that the insurance program established in 1946—a time even further removed from the then-recent analysis the court provided in *Frontiero* and *Reed*. Such programs likely did not anticipate women in the workplace, and likely perceived pregnancy in a stereotypic manner (i.e., perceiving pregnancy-related services to cost disproportionately more than other injuries that could be suffered in the workplace).

Stewart recognized “distinctions involving pregnancy” can be “mere pretexts designed to effect an invidious discrimination.”⁴⁵⁷

Second, despite how scholars have read the case, the Court’s language is unambiguous that selective actions by a state involving pregnancy that are based on pretext for other causes or concerns can be invidious.⁴⁵⁸ It is not the concern of this Article to take up why scholars and courts have misread the case. However, Justice William J. Brennan, Jr.’s powerful dissent may hold relevant clues that must also be understood in context. Brennan’s methodic push for a strict level of scrutiny to be applied in sex discrimination cases surfaced in his dissent in *Geduldig*, but emerged in prior Supreme Court litigation.⁴⁵⁹ Brennan articulated a vision for strict scrutiny jurisprudence in sex cases in *Frontiero*, decided just one year prior to *Geduldig*, and in that case he achieved a plurality decision. In this case, he issued a bristling warning to fend off a rollback on gains secured in prior cases and to hold tight the fragile plurality built on sex classification and strict scrutiny:

Yet, by its decision today, the Court appears willing to abandon that higher standard of review without satisfactorily explaining what differentiates the gender-based classification employed in this case from those found unconstitutional in *Reed* and *Frontiero*. The Court’s decision threatens to return men and women to a time when “traditional” equal protection analysis sustained legislative classifications that treated differently members of a particular sex solely because of their sex.⁴⁶⁰

Over time, perhaps too close a scholarly read of Brennan’s dissent has resulted in a general misevaluation of *Geduldig*. Whatever the case, Brennan’s dissent serves as an evolved framework for equality analyses based on sex and ultimately develops in a line of cases that expanded the counters of sex equality.⁴⁶¹

Finally, *Geduldig* can be understood as a parallel to *Plessy v. Ferguson*.⁴⁶² The gap that separates *Plessy* from *Brown* provides instructive lesson’s for sex equality’s journey. That is, in 1896 when Homer Plessy challenged the

457. *Geduldig v. Aiello*, 417 U.S. 484, 496 n.20 (1974) (noting that “while it is true that only women can become pregnant, it does not follow that every legislative classification concerning pregnancy is a sex-based classification.”)

458. Neil Siegel and Reva Siegel argue that the case “should be read to say what it actually says, not what most commentators and courts have assumed it to say.” See Siegel & Siegel, *Equality Arguments for Abortion Rights*, *supra* note 440, at 168.

459. Brennan specifically speaks to the prior cases where his strict scrutiny jurisprudence on sex emerges, instructing “[b]ecause I believe that *Reed v. Reed*, and *Frontiero v. Richardson*, mandate a stricter standard of scrutiny which the State’s classification fails to satisfy, I respectfully dissent.” *Geduldig*, 417 U.S. at 496, 498 (Brennan, J., dissenting) (internal citations omitted).

460. *Id.* at 503.

461. For example, Brennan’s observation that “singling out for less favorable treatment a gender [characteristic] peculiar to women... create[s] a double standard.” *Id.* at 501.

462. 163 U.S. 537 (1896).

Louisiana Separate Car Act, requiring separate accommodations for African Americans and whites, on the basis that it violated his rights under the Thirteenth and Fourteenth Amendments of the U.S. Constitution, it was a relatively nascent period for the Court's jurisprudence in equal protection. The perceived urgency that those who lived unequal lives felt likely did not influence the Court. The Court rejected Plessy's claims, declaring that Louisiana had not implied any inferior status on African Americans in violation of a Fourteenth Amendment interest.⁴⁶³ However, the Court established a framework that purported to grant African Americans a "separate, but equal" citizenship, which decades later was dismantled by *Brown v. Board of Education*,⁴⁶⁴ a case that ultimately reconciled the folly of the *Plessy* decision. Feminism now awaits its *Brown* to close the gap in equality jurisprudence. Like the evolution between *Plessy* and *Brown*, landmark Supreme Court decisions can be read as demarcating evolving equal protection jurisprudence.⁴⁶⁵

Geduldig offers one important lens to consider in the Court's jurisprudence on pregnancy equality. Another application directly addresses the issue of fetal health protection in the workplace as discussed below.

2. Fetal Protection and the Workplace

In *International Union v. Johnson Controls*, the Supreme Court opined that male health may have as much bearing on fetal outcomes as women's health.⁴⁶⁶ In the decade leading up to *International Union*, prominent manufacturing companies enacted FPLs framed as "medical regulations" or "medical policies" that prohibited fertile women from laboring in certain jobs.⁴⁶⁷ Some policies excluded women from most jobs at the plants under the

463. Justice Brown declared, "We consider the underlying fallacy of the plaintiff's argument to consist in the assumption that the enforced separation of the two races stamps the colored race with a badge of inferiority. If this be so, it is not by reason of anything found in the act, but solely because the colored race chooses to put that construction upon it." *Id.* at 551.

464. *Brown v. Bd. of Educ.*, 347 U.S. 483 (1954).

465. Indeed the equality struggle substantively engages two frames—that of formal equality versus substantive equality.

466. 499 U.S. 187, 188 (1991). The case was perceived as a victory for workplace equality and a judicial vindication of women's rights, particularly in light of how *Geduldig v. Aiello* was read. 417 U.S. 484 (1974). See Mary Becker, *From Muller v. Oregon to Fetal Vulnerability Policies*, 53 U. CHI. L. REV. 1219 (1986); Lucinda Finley, *Transcending Equality Theory: A Way Out of the Maternity and the Workplace Debate*, 86 COLUM. L. REV. 1118 (1986); Hannah Furnish, *Prenatal Exposure to Fetally Toxic Work Environments: The Dilemma of the 1978 Pregnancy Amendment to Title VII of the Civil Rights Act of 1964*, 66 IOWA L. REV. 63 (1980); Linda Howard, *Hazardous Substances in the Workplace: Implications for the Employment Rights of Women*, 129 U. PA. L. REV. 798, 802-06 (1981); Wendy Williams, *Firing the Woman to Protect the Fetus: The Reconciliation of Fetal Protection with Employment Opportunity Goals Under Title VII*, 69 GEO. L.J. 641 (1981).

467. Among the companies that enacted fetal protection rules were American Cyanamid, Allied Chemicals, General Motors, B.F. Goodrich, St. Joseph Zinc, Gulf Oil, Dow Chemical, DuPont, BASF Wyandotte, Bunker Hill Smelting, Eastman Kodak, Firestone Tire & Rubber, Globe Union, Olin Corporation, Union Carbide and Monsanto. See JOAN BERTRIN, *Reproductive Hazards in the*

guise that they might become pregnant at some point, without regard for the women's sexual orientation, desire to bear children, or marital status.⁴⁶⁸

For example, American Cyanide enacted a fetal protection policy in 1978.⁴⁶⁹ Its plant, located in the rolling hills of economically depressed West Virginia, provided a competitive income for its 500 employees—approximately 5 percent were women. Senior management met with its 25 female employees to inform them that women between 15 and 50 years of age would be prohibited from working in most positions at the plant. Other companies enacted similar fetal protection regulations, effectively barring women from employment in some of the better paying jobs at manufacturing plants.⁴⁷⁰

Fetal protection rules in the workplace served not only to bar women from meaningful, gainful employment, but also to secure a monopoly for men in coveted factory jobs. Fetal protection rules provided a persuasive proxy for sex discrimination. Meanwhile, the debate about fetal protection, pregnancy, and access to work opportunities played out in the wake of companies across the country enacting discriminatory laws.

In *International Union*, the company established a FPL much like that of American Cyanide.⁴⁷¹ The company's manufacturing operation involved lead elements, which can pose fetal health risks. This had not been a concern for the company in the years prior to the Civil Rights Act of 1964, because the company did not employ any woman in its battery-manufacturing factory.⁴⁷² However, in June of 1977, the company issued "its first official policy concerning its employment of women in lead-exposure work."⁴⁷³ The policy read:

Protection of the health of the unborn child is the immediate and direct responsibility of the prospective parents. While the medical profession and the company can support them in the exercise of this

Workplace, in REPRODUCTIVE LAWS FOR THE 1990s 277, 301 n.5 (Sherrill Cohen & Nadine Taub eds., 1989).

468. See *id.* at 277.

469. *Id.*

470. *Id.* Similar dynamics played out with regard to race during Jim Crow. That is, African Americans and other groups of color were discriminated against on the basis of pretext, even within unions. See PAUL MORENO, BLACK AMERICANS AND ORGANIZED LABOR: A NEW HISTORY 61–63 (2006) (describing the violent events at Pana, Illinois where several African Americans were killed in retaliation for seeking to cross union lines). See also HORACE R. CAYTON, BLACK WORKERS AND THE NEW UNIONS (1939); STERLING D. SPERO & ABRAM L. HARRIS, THE BLACK WORKER: THE NEGRO AND THE LABOR MOVEMENT (1931); Note, *Discrimination by Labor Union Bargaining Representatives Against Racial Minorities*, 56 YALE L.J. 731 (1947) ("Discrimination by labor unions against racial minorities, particularly Negroes, is still frequent despite reforms by some unions in recent years. Some unions positively refuse membership to Negroes. Others relegate them to 'auxiliary' chapters under the domination of white locals, where they pay dues to the union but have no effective voice in its affairs.").

471. *Int'l Union v. Johnson Controls*, 499 U.S. 187, 191 (1991).

472. *Id.*

473. *Id.*

responsibility, it cannot assume it for them without simultaneously infringing their rights as persons.

. . . . Since not all women who can become mothers wish to become mothers (or will become mothers), it would appear to be illegal discrimination to treat all who are capable of pregnancy as though they will become pregnant.⁴⁷⁴

At the time that Johnson issued its official policy statement, it stopped short of restricting women of childbearing capacity from working within lead exposed areas.⁴⁷⁵ However, the company issued strong warnings to its female employees about lead risks.⁴⁷⁶ It also instituted a policy that “required a woman who wished to be considered for employment to sign a statement that she had been advised of the [pregnancy] risk.”⁴⁷⁷ The statement informed female employees that while evidence indicated “that women exposed to lead have a higher rate of abortion” and although this risk was “not as clear . . . as the relationship between cigarette smoking and cancer,” it was “medically speaking, just good sense not to run that risk if you want children and do not want to expose the unborn child to risk, however, small.”⁴⁷⁸

Several years later, Johnson Controls shifted their policy from one that cautioned female employees about the risks of lead exposure to fetal development to a policy that excluded women’s employment in manufacturing jobs that could expose them to lead. The company barred all women, except those who could prove infertility, from holding certain jobs that could expose them to lead.⁴⁷⁹ The new fetal protection policy stated: “It is Johnson Controls’ policy that women who are pregnant or who are capable of bearing children will not be placed into jobs involving lead exposure or which could expose them to lead through the exercise of job bidding, bumping, transfer or promotion rights.”⁴⁸⁰

Johnson Controls initiated the new fetal protection policy after learning that eight of its female employees who became pregnant continued to test high for lead exposure.⁴⁸¹ The new company policy defined women who are “capable of bearing children” as “all women except” the infertile.⁴⁸² The female employees were required to medically demonstrate their infertility.⁴⁸³ These were hurdles that male employees were not required to scale.

474. *Id.*

475. *Id.*

476. *Id.*

477. *Id.*

478. *Id.*

479. *Id.* at 191–92.

480. *Id.* at 192.

481. *Id.*

482. *Id.*

483. *Id.* at 192.

Importantly, the company did *not* bar all men “except those whose infertility was medically documented, from jobs involving actual or potential lead exposure exceeding the OSHA standard.”⁴⁸⁴

Johnson Controls justified its policy based on concerns for fetal health,⁴⁸⁵ which the Court nevertheless rejected. Writing for the majority, Justice Harry A. Blackmun, found the fetal protection policy established by Johnson Control “obvious” in its “bias” against women.⁴⁸⁶ For example, fertile men were not subjected to the burdensome employment restrictions placed on fertile women. Fertile men, according to the Court, were afforded the “choice as to whether they wish to risk their reproductive health for a particular job.”⁴⁸⁷ The Court revisited Section 703(a) of the Civil Rights Act of 1964,⁴⁸⁸ explaining that it “prohibits sex-based classifications in terms and conditions of employment, in hiring and discharging decisions, and in other employment decisions that adversely affect an employee’s status.”⁴⁸⁹

Blackmun reasoned that a sex-based policy expressed as “protecting women’s unconceived offspring” was not benign.⁴⁹⁰ To the contrary, such policies constitute sex-based discrimination according to the Court. Any assumptions otherwise are “incorrect.”⁴⁹¹ Justice Blackmun reasoned that the policy constituted facially impermissible discrimination.⁴⁹² For example, the fetal protection policy classified its employees on the basis of gender and childbearing capacity rather than just fertility.⁴⁹³ Moreover, the company did not care to protect its male employees’ future born from possible risk of lead exposure, despite, as the record showed, “the debilitating effect of lead exposure on the male reproductive system.”⁴⁹⁴ In other words, it was sex and not fetal health that ultimately proved important to the company for purpose of its regulation. As Blackmun referenced, the company is “concerned only with the harms that may befall the unborn offspring of its female employees.”⁴⁹⁵

Conceptually, that type of bias cannot pass constitutional muster, because it is a form of explicit discrimination that cannot survive judicial scrutiny. In

484. *Id.*

485. *Id.* at 197, 202 (noting “[t]he policy excludes women with childbearing capacity from lead-exposed jobs and so creates a facial classification based on gender. Respondent assumes as much in its brief before this Court.”).

486. *Id.* at 197.

487. *Id.*

488. 78 Stat. 255, as amended, 42 U. S. C. § 2000e-2(a).

489. *Int’l Union*, 499 U.S. at 197.

490. *Id.* at 198.

491. *Id.*

492. *Id.*

493. *Id.* at 198.

494. *Id.*

495. *Id.*

this case, the company “chose[] to treat all its female employees as potentially pregnant,” and that policy evinces a form of unjustifiable sex discrimination.⁴⁹⁶

Unambiguous rules emerge from the Court’s analysis and subsequent holding. For example, classifications on the basis of “potential for pregnancy” impermissibly exclude women.⁴⁹⁷ Second, that type of exclusion, under Title VII, must be viewed “in the same light as explicit sex discrimination.”⁴⁹⁸ Third, the fetal protection policy was not neutral as it did not apply to the reproductive potential and capacities of Johnson’s male employees.⁴⁹⁹ Fourth, the Court is not concerned with the absence of malevolent motives, because that does not “convert a facially discriminatory policy” into a policy that is neutral with discriminatory effect.⁵⁰⁰ Equally, a beneficent policy will not distract from the Court’s analysis and undermine the purpose of equal protection. Fifth, “sex-specific fetal protection policies” in employment are forbidden under Title VII.⁵⁰¹ And, subjecting all of one’s female employees to a discriminatory policy that protects fetal health will constitute a violation of the Equal Protection Clause because it demonstrates discrimination on the basis of sex.⁵⁰²

The majority reasoned that unless Johnson Controls could somehow prove that sex was a “bona fide occupational qualification,” a very narrow exception at that point in the Court’s jurisprudence, the holding would stand.⁵⁰³ Johnson Control responded that its policy involved third-party safety, an argument that the Court forthrightly rejected, because the female employees’ unconceived fetuses were not third parties.⁵⁰⁴ Even if they were third parties, their safety was not essential. As Blackmun wrote, “No one can disregard the possibility of injury to future children,” but the business exception claimed by Johnson Controls was not deserving of the special solicitude it demanded of the Court.⁵⁰⁵ According to Blackmun, battery making was not so essential as to overcome the Court’s suspicion of regulations that discriminate on the basis of sex even if to theoretically protect unborn third parties.⁵⁰⁶ The Court declined

496. *Id.* at 199.

497. *Id.*

498. *Id.* at 199.

499. *Id.*

500. *Id.* (stating that “[w]hether an employment practice involves disparate treatment through explicit facial discrimination does not depend on why the employer discriminates but rather on the explicit terms of the discrimination.”).

501. *Id.* at 211.

502. The Court found the fetal protection policy was discriminatory under the Pregnancy Discrimination Act of Title VII. The Court held that Title VII as amended by the Pregnancy Discrimination Act forbids “sex-specific fetal-protection policies.” Civil Rights Act of 1964, 42 U.S.C. § 2000e(k); *Int’l Union*, 499 U.S. at 189.

503. *International Union*, 499 U.S. at 200.

504. *Id.* at 203.

505. *Id.* at 203–04.

506. The Court further clarifies, “Our case law . . . makes clear that the safety exception is limited to instances in which sex or pregnancy actually interferes with the employee’s ability to perform the job.” *Id.* at 204.

to adopt a policy that would allow the application of fetal protection policies to mandate selective “standards for pregnant or fertile women.”⁵⁰⁷

It is worth thinking about Justice Blackmun, *International Union* (1991), and *Planned Parenthood of Southern Pennsylvania v. Casey* (1992)⁵⁰⁸ just briefly. Linda Greenhouse writes persuasively about how Blackmun’s equality jurisprudence evolved during his time on the bench.⁵⁰⁹ For example, in *Johnson Controls*, Blackmun is unequivocal in his reasoning that women possess decisional authority to do as they please with their bodies. Blackmun considers this concept unremarkable and well established in legislation that further extends women’s rights. Blackmun’s conclusion, “it is no more appropriate for the courts than it is for individual employers to decide whether a woman’s reproductive role is more important to herself and her family than her economic role,”⁵¹⁰ presages and sets up his written opinion in *Casey*.

In *Casey*, Blackmun refers to choice and not simply substantive due process arguments in articulating a vision for “women to be equal to men under the Constitution. Specifically, Blackmun writes in passionate prose about sparing women’s equality from being “cas[t] into darkness.”⁵¹¹ He explains, “State[] restrictions on a woman’s right to terminate her pregnancy . . . implicate constitutional guarantees of gender equality.”⁵¹² When the state burdens this right, it “conscripts women’s bodies into its service.”⁵¹³ Blackmun warned that “forcing women to continue pregnancies and suffer the pains of childbirth” assigns women a life-long bondage to the state without any compensation to “women for their services.”⁵¹⁴ Indeed, assumptions about motherhood and what is “natural” rest on a faulty conception, which elicits protection of the Equal Protection Clause.⁵¹⁵

3. Means, Ends, and Chilling Prenatal Conduct

Because a close reading of *Geduldig* preserves equal protection challenges in matters of invidious state discrimination against pregnant women, this Article proceeds by turning to its normative argument that FPLs violate the Equal Protection Clause of the U.S. Constitution. This and subsequent Sections advance an analysis based on what *Geduldig* should be read to say in light of the Court’s full opinion in that case as well as *International Union*, which serves as a reasonable guidepost. Finally, even a conservative reading of

507. *Id.*

508. *Planned Parenthood v. Casey*, 505 U.S. 833 (1992) (split decision reaffirming *Roe v. Wade*, while permitting Pennsylvania to regulate certain aspects of abortion.).

509. See Greenhouse *supra*, note 437.

510. *Int’l Union*, 499 U.S. at 211.

511. *Casey*, 505 U.S. at 922.

512. *Id.* at 928.

513. *Id.*

514. *Id.*

515. *Id.*

Geduldig should be reconciled by an evolved equal protection jurisprudence advanced and cultivated by the Court in the years since 1974 as evidenced through *International Union* as well as *Nevada Department of Human Services v. Hibbs*.⁵¹⁶

To understand invidious pregnancy discrimination as “never” evincing impermissible sex discrimination risks ignoring the expansive equal protection landscape cultivated by the Court. By modest analogy, it would be similar to focusing race equality analysis on *Plessy v. Ferguson*.⁵¹⁷ I will not repeat the arguments made earlier that resituate *Geduldig* from the conventional reading that pregnancy discrimination can never be sex discrimination. As Professors Neil Siegel and Reva Siegel explain, that reading is plainly inaccurate.⁵¹⁸ If the conventional interpretation of *Geduldig* offers an inexact understanding of the case, how should this be reconciled in light of the interests at stake?

The clearest approach is to adopt the standard flagged in footnote twenty of the majority’s opinion. In that footnote, Justice Stewart explained that “distinctions involving pregnancy” may impose “an invidious discrimination against the members of one sex or other.”⁵¹⁹ Giving this expression from the Court full weight, the following arguments proceed on the basis that invidious pregnancy discrimination should be analyzed as sex discrimination under the Equal Protection Clause.⁵²⁰

Prosecuting women, but not men, for violating fetal protection statutes constitutes discrimination against women. Simply stated, the means and ends do not fit. At best, locating fetal harms as the exclusive control of women “must be considered an unduly tenuous ‘fit.’”⁵²¹ Dating back to *Reed v. Reed*⁵²²

516. 538 U.S. 721 (2003) (According to the Court, “[m]any States offered women extended ‘maternity’ leave that far exceeded the typical 4- to 8-week period of physical disability due to pregnancy and childbirth, but very few States granted men a parallel benefit: Fifteen States provided women up to one year of extended maternity leave, while only four provided men with the same.” (quoting M. LORD & M. KING, *THE STATE REFERENCE GUIDE TO WORK-FAMILY PROGRAMS FOR STATE EMPLOYEES* 30 (1991)). The Court noted that pregnancy discrimination had become intractable and pervasive.

517. Being stuck in a *Plessy* moment would require ignoring the fact that the country in which we live is vastly different than it was at the time of the decision’s iteration.

518. See Siegel & Siegel, *supra* note 440, at 167 (arguing that the conventional reading of *Geduldig* is “incorrect”).

519. See Siegel & Siegel, *supra* note 440, at 167.

520. Finally, insights can be drawn from *Nevada Department of Human Services v. Hibbs*. 38 U.S. 721 (2003). In that case, the Supreme Court ruled that family leave policies discriminated against men by providing reduced time compared to that granted women to care for a family members. This constituted sex discrimination. The Court relied on expert documents and legislative history associated with the Family Medical Leave Act to point out how discriminatory stereotypes about pregnancy and sex roles has influenced the construction and implementation of state pregnancy and family leave policies. The court found that discriminatory implementation of family leave policies based on gender violated the Equal Protection Clause.

521. *Craig v. Boren*, 429 US 190, 202 (1976).

522. *Reed v. Reed*, 404 U.S. 71 (1971) (invalidating a law permitting preferences of men over women in the appointment of estate administrators).

and *Frontiero*,⁵²³ the Court has found that statutory classifications that distinguish between males and females are “subject to scrutiny under the Equal Protection Clause.”⁵²⁴ To withstand constitutional scrutiny, discrimination based on gender must serve important government objectives and be substantially related to achievement of those objectives.⁵²⁵

In *Craig v. Boren*, the Supreme Court carved out an intermediary level of scrutiny for sex-based discrimination.⁵²⁶ In that case, the Court struck down an Oklahoma law prohibiting alcohol sales to adult males. The Court held that the law discriminated against young males, but not females, because it prohibited sales of a nonintoxicating beer to males under twenty-one and to females under eighteen.⁵²⁷ The Court found that the means—discriminating against young men by denying them the right to purchase beer—was not substantially related to Oklahoma’s purported end—promoting traffic safety.⁵²⁸ The Court acknowledged the importance of traffic safety, although perhaps not to the degree Justice Rehnquist did in his dissent.⁵²⁹ The majority reasoned that even though “arrest statistics assembled in 1973 indicated that males in the 18-20 age group were arrested for ‘driving under the influence’ almost 18 times as often as their female counterparts, and for ‘drunkenness’ in a ratio of almost 10 to 1,”⁵³⁰ singling out one sex for gender discrimination was impermissible where the means of reducing traffic deaths and injuries was tenuously connected to the end—even if the end was socially important.⁵³¹ These early

523. *Frontiero v. Richardson*, 411 U.S. 677 (1973) (opining that laws granting male members of the armed forces an automatic dependency allowance for their wives, but denying the same for women and their husbands, violated the Equal Protection Clause). According to Justice Brennan, “classifications based upon sex, like . . . race, alienage, and national origin, are inherently suspect and must therefore be subjected to close judicial scrutiny.” *See id.* at 688 (Brennan, J., concurring).

524. *Reed*, 404 U.S. at 75.

525. *Id.* at 75–76.

526. *See Craig*, 429 U.S. 190.

527. *Id.*

528. The statute under review contained two sections that prohibited the sale of “nonintoxicating” 3.2% beer to males under the age of 21 and to females under the age of 18.” *Id.* at 190.

529. *See id.* at 224 (Rehnquist, J., dissenting).

530. *Id.* at 223.

531. The Justices were unpersuaded by data showing that “over three-fourths of the drivers under 20 in the Oklahoma City area [were] males, and that each of them, on average, drives . . . many [more] miles per year as their female counterparts; [and] that four-fifths of male drivers under 20 in the Oklahoma City area state a drink preference for beer, while about three-fifths of female drivers of that age state the same preference.” *Id.* Neither was the Court persuaded that the law could withstand intermediate scrutiny despite the fact that “93% of all persons arrested for drunken driving were male” between 1967 and 1972. In a footnote, Justice Brennan, who delivered the opinion for the Court, cautioned that social stereotypes were reflected in the Oklahoma law and the stereotypes were likely to distort how legislators and even police officers interpreted traffic violations. *Id.* Brennan cautioned that “social stereotypes” that make their way into legislation “are likely substantially to distort the accuracy of . . . comparative statistics.” *Id.* As an example, Brennan pointed to common social stereotypes as possibly influencing law enforcement. For example, if police perceive young men as “reckless” drinkers who drive, that presumption may lead to or be “transformed into arrest statistics.” On the

cases helped establish the Court's evolving jurisprudence on sex discrimination and the Equal Protection Clause. The Court's early holdings indicate that even protectionist legislation is not spared a heightened scrutiny when sex-based restrictions are applied in arbitrary ways.⁵³²

When states single out one sex for discriminatory purposes, including prosecution, forced bed rest, life support, and cesarean surgery interventions, they should provide "an exceedingly persuasive justification," as articulated in *United States v. Virginia*.⁵³³ This is a demanding burden to meet, because states must show that singling out women for punitive action serves "important governmental objectives and that the discriminatory means employed [are] substantially related to the achievement of those objectives."⁵³⁴ Moreover as these laws relate to fetal health, states should be made to demonstrate how such policies actually promote fetal health.

For example, the best fetal protection efforts taken by pregnant women will involve seeking prenatal services.⁵³⁵ Prenatal care provides the opportunity for information sharing between doctors and patients and affords patients the opportunity to address health and emotional concerns about the pregnancy, receive advice regarding diet management, and monitor fetal health and development.⁵³⁶ Health care providers consider prenatal care to be an essential component of gestation.⁵³⁷

Yet, a series of cases documented by the National Advocates for Pregnant Women reveal that the overwhelming majority of intrusive state interventions, including arrests and confinement, are initiated by prenatal or medical visits at hospitals and clinics.⁵³⁸ Sometimes the women are arrested at the clinics.⁵³⁹ Ultimately, intervening in women's pregnancies at prenatal appointments may chill the very behavior that government desires to promote.⁵⁴⁰ When states chill

other hand, young women may slide under the radar, including those who are "reckless" or "drunk drivers" based on other stereotypes and entrenched views about women's femininity and temperance. As to the latter, Brennan cautioned that young women may be under-policed or not policed for drunk driving. Rather than ticketing or arresting young women, Brennan surmised that officers "chivalrously escorted [them] home" for the same type of offenses that might have landed young men in jail. *Id.* at 223.

532. *Id.* at 202.

533. *See, e.g.,* *United States v. Virginia*, 518 U.S. 515, 531 (1996).

534. *See* *Wengler v. Druggists Mut. Ins. Co.*, 446 U.S. 142, 150 (1980).

535. *See generally* *What is Prenatal Care and Why is it Important?*, NAT'L INST. CHILD HEALTH & HUMAN DEV., <http://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/Pages/prenatal-care.aspx> (describing the importance of prenatal care for a healthy pregnancy and healthy infant) (last updated July 12, 2013).

536. *Id.*

537. *Id.* ("having a healthy pregnancy is one of the best ways to promote a healthy birth.").

538. Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL'Y & L. 299, 300 (2013).

539. *Id.* at 334.

540. *Id.* at 330.

prenatal care, they erode the best avenue for achieving the healthiest outcomes for babies.⁵⁴¹ One researcher warns that the “[u]ncomfortable relationships with health care providers and fear of reprisal on the part of pregnant women who are addicted make women four times less likely to receive adequate care, thereby creating health risks for women who are addicted, their unborn fetuses, and their other children.”⁵⁴² The National Women’s Law Center echoes these concerns⁵⁴³ as have the American Medical Association,⁵⁴⁴ the Center for Reproductive Rights,⁵⁴⁵ and The National Partnership for Women & Families, and professional organizations, such as the American Public Health Association, and the American College of Obstetrics and Gynecology, to name a few.

If using prenatal services is one of the best ways to promote fetal health, chilling that conduct will not achieve government interests. Instead, it may very well undermine child and maternal welfare by creating an “unsafe” harbor around clinics and hospitals. Some scholars predict that women who can afford to end their pregnancies may seek abortions to avoid hospital “dragnets” altogether.⁵⁴⁶ Others suggest that pregnant women will simply avoid medical screenings.⁵⁴⁷ In either case, state encroachments of the type described in this Article fail to credibly engage in the means and ends analysis established as part of the Supreme Court’s equal protection jurisprudence.

4. State Action and Stereotypes

Selective, punitive interventions in pregnant women’s lives evince motivations other than protecting fetal health. Selective state action that singles out poor pregnant women to give birth to healthier babies while not imposing similar conditions and constraints on all others capable of fertility “reflect[s] constitutionally suspect judgments”⁵⁴⁸ about that class of pregnant women. In *International Union*, Justice Blackmun warned that discriminatory fetal protection policies that impose special conditions on fertile women are virtually

541. CENTER FOR REPRODUCTIVE RIGHTS, PUNISHING WOMEN FOR THEIR BEHAVIOR DURING PREGNANCY 4 (2000), available at http://reproductiverights.org/sites/default/files/documents/pub_bp_punishingwomen.pdf (noting that punishing pregnant drug users is “counterproductive or run[s] contrary to public policy”).

542. Carolyn S. Carter, *Perinatal Care for Women Who Are Addicted: Implications for Empowerment*, 27 HEALTH & SOC. WORK 166, 167 (2002) (citation omitted).

543. Brief Amici Curiae for National Women’s Law Center, et al. In Support of Respondent, *State v. Martinez*, 137 P.3d 1195 (N.M. 2006) (No. 29,775), 2007 WL 5120947.

544. Brief for APHA et al. for Petitioner, *supra* note 236.

545. CENTER FOR REPRODUCTIVE RIGHTS, *supra* note 541.

546. For example, Carmen Howell, a defense lawyer in Alabama, is “concerned that women who use drugs may also be having abortions to avoid prosecution.” Calhoun, *supra* note 80.

547. See, e.g., Elizabeth L. Thompson, *The Criminalization of Maternal Conduct During Pregnancy: A Decisionmaking Model for Lawyers*, 64 IND. L.J. 357, 370 (1989) (“Perhaps the greatest danger in adopting a statutory scheme of fetal neglect or endangerment laws is that it will, in fact, deter women from seeking prenatal care for fear of being ‘turned-in’ by their doctors.”).

548. See Siegel & Siegel, *supra* note 440, at 163.

impossible to justify, because the Equal Protection Clause is intolerant of sex discrimination, even when it is motivated by beneficence.⁵⁴⁹ However, the Court has found that policies that discriminate based on sex may be influenced by stereotypes about sex as well as about gender roles.⁵⁵⁰

One stereotype reflected in fetal protection measures is that women alone control fetal health. While women do play an undeniably vital role in the care and gestation of fetuses, they do not exclusively control fetal health. To the contrary, numerous empirical studies indicate that fetal health is not controlled exclusively by pregnant women,⁵⁵¹ because environment contributes significantly to fetal health. Scholars have acknowledged this much for some time, and so have courts.⁵⁵²

The aftermath of generations of legally and socially permissible sex discrimination, according to Brennan, results in legislation “laden with gross, stereotyped distinctions between sexes.”⁵⁵³ The sex-based stereotyping Brennan critiqued four decades ago in *Frontiero* and *Craig* persists in the fetal protection sphere.

For example, poor pregnant women and women of color are criminally hyper-policed during pregnancy to reduce the incidence of low birth weight and miscarriage in ways that neither men, nor wealthier, white women experience.⁵⁵⁴ Dr. Allen A. Mitchell’s research on prescription drug dependency during pregnancy provides empirical heft to buttress intuitions that stereotyping occurs in the drafting and enforcement of FPLs. Mitchell, who serves as Director of the Slone Epidemiology Center, debunks commonly held presumptions about drug use during pregnancy, which likely drive the enactment and enforcement of FPLs.⁵⁵⁵ Longitudinal studies conducted by Mitchell and other scientists find that educated white women are more likely to rely on prescription medications during pregnancy and their dependency on

549. *Int’l Union v. Johnson Controls*, 499 U.S. 187, 200 (1991).

550. *Id.* at 211 (stating that it is not appropriate for the courts or employers “to decide whether a woman’s reproductive role is more important to herself and her family than her economic role”).

551. *See, e.g., Rowland, supra* note 153.

552. *See, e.g., Daubert v. Merrell*, 509 U.S. 579 (1993) (illustrating the difficulty in establishing whether drugs or other factors cause birth defects); *Int’l Union*, 499 U.S. at 200 (rejecting fetal protection regulation even though work environment exposed women to lead, which has a demonstrated association with negative fetal and child health); *Ambrosini v. Labarraque*, 101 F.3d 129, 131–32 (D.C. Cir. 1996) (finding causal connection between medroxyprogesterone exposure and fetal birth defects); *Mahon v. Pfizer, Inc.*, No. 110511/10 (N.Y. Sup. Ct. Dec. 2, 2011), *available at* http://scholar.google.com/scholar_case?case=12702520309402028215&hl=en&as_sdt=6&as_vis=1&oi=scholar (denying company’s motion to dismiss case alleging fetal harms were caused through the mother’s wrongful exposure to defendant’s product).

553. *Frontiero v. Richardson*, 411 U.S. 677, 685 (1973).

554. *See generally* Roberts, *supra* note 5 (discussing the disproportionate targeting and government intrusion into the lives of women of color, particularly in the realm of reproduction).

555. *See* Allen A. Mitchell et al., *Medication Use During Pregnancy, with Particular Focus on Prescription Drugs: 1976–2008*, 205 AM. J. OBSTETRICS & GYNECOLOGY 51.e1 (2011).

these medications increases by age.⁵⁵⁶ His research findings demonstrate that during the first trimester of pregnancy, over 70 percent of women reported taking at least one medication that was not a vitamin or mineral and that drug use increased with age, and also by race.⁵⁵⁷ Moreover, Mitchell and his colleagues surmise that educated, white women are more likely to take prescription medications during pregnancy generally, and use more prescription medications during pregnancy as they age.⁵⁵⁸

The Court would find it relevant that in light of rigorous evidence demonstrating a risk of fetal harm based on prescription drug use, states ignore that cohort of gestating mothers. Instead, they target poor users of illicit substances.⁵⁵⁹ In other words, despite the dramatic rise in prescription pain relief during pregnancy, which is directly linked to wealth and race, states rely on stereotypes, targeting poor women primarily.⁵⁶⁰

Finally, the Supreme Court emphasizes that states cannot craft laws that spare some members of a class indignities and yet subject others to surreptitious law-enforcement dragnets when they seek prenatal care.⁵⁶¹ Can states make a case that is exceedingly persuasive why some women, particularly poor women, are singled out to birth the healthiest babies when others are not? In *United States v. Virginia*, Justice Ginsburg opined that “[t]he burden of justification is demanding and it rests entirely on the State.”⁵⁶² Inherent differences between men and women or different categories of women pose “artificial constraints on an individual’s opportunity,”⁵⁶³ and cannot be

556. *Id.* at 51.e4–e5.

557. *Id.* at 51.e3–e4.

558. *Id.* at 51.e4–e5.

559. *See* Ferguson v. Charleston, 532 U.S. 67 (2001); Paltrow & Flavin, *supra* note 4, at 300; Roberts, *supra* note 5, at 1432–33 (discussing how public hospital patient populations and hospital screening practices “result in disproportionate reporting of poor Black women”); Ada Calhoun, *The Criminalization of Bad Mothers*, N.Y. TIMES, Apr. 25, 2012, <http://www.nytimes.com/2012/04/29/magazine/the-criminalization-of-bad-mothers.html?pagewanted=all> (reporting how poor pregnant illicit drug offenders in Alabama are being charged with child endangerment); Adam Nositer, *In Alabama, a Crackdown on Pregnant Drug Users*, N.Y. TIMES, Mar. 15, 2008, <http://www.nytimes.com/2008/03/15/us/15mothers.html?pagewanted=all&r=0> (relating stories of women in Alabama prosecuted for using drugs while pregnant).

560. *See also* Ferguson v. Charleston, 532 U.S. 67 (2001). In *Mississippi University for Women v. Hogan*, the Court cautioned that the test for determining the validity of gender-based discrimination is “straightforward,” and “must be applied free of fixed notions concerning the roles and abilities of males and females.” Again, the Court cautioned against discrimination based on archaic stereotypes. Archaic stereotypes in these contexts include the assumption that pregnant women hold exclusive control over fetal health outcomes and that women of color are more likely to engage in behavior that may put the fetus at risk than other pregnant women—hence the persistent policing.

561. *See, e.g.*, Project Export, *Health Disparities I-95 Corridor*, MED. UNIV. OF S.C., http://export.musc.edu/health_disparities/health_disparities.html (last visited Apr. 17, 2014) (noting the health disparity of the predominantly African American and low-income population along the I-95 corridor).

562. *United States v. Virginia*, 518 U.S. 515, 533 (1996).

563. *Id.*

used as they were in prior generations to “create or perpetuate the legal, social,” and reproductive “inferiority” of women.⁵⁶⁴

CONCLUSION

This Article has shown how fetal protection efforts, while intending to promote fetal health, impose onerous burdens on the most vulnerable members of our society: pregnant women. These burdens emerge during pregnancy in some of the cruelest ways, invading their privacy, ignoring their confidence, trampling their autonomy, and imposing physically abusive norms on their bodies. Ultimately, such policies do very little to achieve states’ interests in fetal protection.

Punitive FPLs simply do not work. They concentrate on the unborn at the risk of ignoring those who are born. How do we resolve this? What policy answers the purported concerns of the state, while affording pregnant women dignity, citizenship, and equality?

This Article takes some steps toward answering those questions, unpacking the many tensions and complexities undergirding fetal protection policy. As a normative matter, the Article argues that the patient-physician relationship must shift in light of states increasingly turning to doctors as their quasi-law-enforcement gatekeepers. To pragmatically engage with that shift, the Article argues for a new standard in medicine and law that resituates the patient-physician relationship, incorporating more of the types of standards and expectations that flow between lawyers and their clients. Second, the Article offers a constitutional framework for thinking about potential constitutional challenges to these laws. Finally, the Article argues that pregnancy discrimination is sex discrimination. As such, it explains why the Court’s equal protection jurisprudence should apply in fetal protection cases.

564. *Id.* at 534.

